HEALTH INSURANCE OPTIONS: EXPANDING COVERAGE UNDER MEDICARE AND OTHER PUBLIC HEALTH INSURANCE PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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HEALTH INSURANCE OPTIONS: EXPANDING COVERAGE UNDER MEDICARE AND OTHER PUBLIC HEALTH INSURANCE PROGRAMS

TUESDAY, JUNE 12, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 10 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
FRIDAY, MAY 25, 1990

PRESS RELEASE #31
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HEALTH INSURANCE OPTIONS: EXPANDING COVERAGE UNDER MEDICARE AND OTHER PUBLIC HEALTH INSURANCE PROGRAMS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health insurance options: expanding coverage under Medicare and other public health insurance programs. The hearing will be held on Tuesday, June 12, 1990, beginning at 10:00 a.m., in B-318 Rayburn House Office Building.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

This will be the fifth hearing in this Congress in the Subcommittee's ongoing investigation of options for universal health insurance coverage.

The hearing will focus on options for coverage developed by State governments, options developed by the Office of Personnel Management (OPM) for the Federal Employees Health Benefits Program (FEHBP), and expansion of the Medicare program to groups other than the elderly and disabled. The relationship of these programs or proposals to options for general Federal health insurance legislation will be explored.

Numerous States have proceeded to develop, or are in the process of developing, programs to cover the uninsured and/or to reform the health insurance market. Hawaii has mandated that all employers provide health insurance and has developed a program, the State Health Insurance Program (SHIP), to provide low-cost coverage to those individuals who fall between Medicaid and employment-based coverage. Massachusetts is in the process of implementing similar legislation, while other States, including Washington, New York, California, and Michigan are developing proposals.

On March 1, 1990, OPM submitted recommendations for reform of the FEHBP to the Congress. In making its recommendations, OPM investigated a number of issues which are relevant to the larger question of assuring access to the entire U.S. population. These issues include: risk selection or segmentation in the market for health insurance and its effect on higher-risk individuals or groups; ability of consumers to make informed choices regarding health insurance; cost-effectiveness of numerous, competing entities administering health insurance with the attendant administrative costs; alternative approaches to cost containment; and malpractice reform.

The Subcommittee will also consider options to expand the Medicare program to groups other than the aged and disabled. For example, approximately 12 percent of Social Security cash recipients between the ages of 62 and 64 are without health insurance. Among spouses of Medicare beneficiaries under the age of 65, 18 percent are without health insurance.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, June 29, 1990, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE FORMATTING REQUIREMENTS BELOW:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman STARK. The subcommittee will continue its hearings on health insurance today with a discussion of expanding coverage under Medicare and other public health insurance programs, focusing on options for coverage developed by State governments and for expansion of the Medicare programs to groups other than the elderly and disabled.

Numerous States have developed, or are in the process of developing, programs to cover the uninsured and to reform the health insurance system. Hawaii has mandated that all employers provide health insurance and has developed a program called SHIP, State health insurance program, to provide low-cost coverage to those individuals who fall in between Medicaid and employment-based coverage.

Massachusetts is in the process of implementing similar legislation. Washington, New York, California, and Michigan are working on proposals. Discussions have been going on at the Federal level, but we have not been making the kind of progress that a number of States have.

We can learn a great deal from the experience of these States, and I hope to explore with our witnesses the relationship of these programs with options to general Federal health insurance legislation.

I look forward to exploring whether States should be able to buy into the Medicaid program on behalf of the uninsured in each State. In this way, States would benefit from Medicare's buying power and its existing reimbursement and administrative structures. You all know what those are, you know their weaknesses and their benefits.

We will also examine options to expand Medicare coverage to groups other than the elderly and disabled. We have got a million uninsured spouses and dependents of Medicare beneficiaries. We have got 400,000 uninsured Social Security cash recipients that retire at age 62. We have uninsured disability recipients who are waiting up to 29 months before becoming eligible Medicare.

We would like to examine today the feasibility for the particularly vulnerable portion of the population to become eligible to buy into the Medicare program.

We think we know what the cost would be—although the social costs, we suspect, are not great. The money costs that you will hear the Chair refer to a lot during the day are $1,000 for an under-65 adult, $1,000 a year to provide them Medicare coverage with a $2,000 out-of-pocket cap, and with first dollar coverage for children and pregnant mothers.

This figure is only good if we don't have great adverse selection and have a broad enough group, I might add, but it is interesting to keep that estimated cost to the Government in mind, as we talk about expansion.

We were slated to begin with a panel of witnesses, but it is my understanding that our witness from the State of Hawaii is not here yet, and if that is still the case, we could begin with Dr. Karen Davis, who is chairman of the Department of Health Policy and Management at Johns Hopkins School of Public Health.

I would like to recognize Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman. And I want to thank you for calling this hearing.

My reason for looking forward to this hearing may be slightly different from your own. I am not that excited about getting ideas from the States about how Washington can set up a national program, I am far more interested from these hearings, and others like it, to find out what the Federal Government can do to help the States set up their own programs.

I think that we already know that there are impediments in current Federal law, ERISA comes to mind, Medicaid comes to mind, where waivers of one kind or the other by the Federal Government can permit a much more lively experimentation by the States in doing what they may choose to do in filling the real acknowledged gaps which exist in health care in this country.

So, I find this hearing extremely timely, and I most sincerely want to thank you for scheduling it.

Chairman STARK. Praise, however faint, is always welcomed in this committee, Mr. Gradison.

For more of the same, we will turn to our distinguished colleague from Baltimore.

Mr. CARDIN. Thank you, Mr. Chairman.

I want to thank you for holding these hearings, and I want to welcome Karen Davis to our committee. I have had the opportunity to work with Karen in the Third District of Maryland, and we are very proud of her work, and it is nice to see her here today.

Chairman STARK. Karen, welcome back. I would like to second Ben's statement and ask you to proceed to enlighten us in any way you are comfortable.

STATEMENT OF KAREN DAVIS, PH.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, JOHNS HOPKINS SCHOOL OF PUBLIC HEALTH, BALTIMORE, MD.

Ms. DAVIS. Thank you, Mr. Chairman, members of the committee. It is a great privilege to be here to talk about the problems of older uninsured, older adults.

There have been proposals advanced to deal with the problems of the uninsured. Many have focused on children or working families, or perhaps expansion of Medicaid to cover the poor, but I think these proposals are not adequate to deal with, namely, uninsured older adults between the ages of 50 and 64.

These people include early retirees. They include people who have become disabled, or who had to leave their job for health reasons, and people who have been forced out of their jobs.

Others are people who have lost health insurance coverage through the death of a spouse, divorce, even retirement of a spouse who may be eligible for Medicare, but whose wife, for example, may not yet qualify for Medicare.

Gaps in health insurance coverage for the older population are particularly serious, because these people can be quite sick, and therefore, at risk for quite substantial health care expenses.

I would like to share with you some new findings from a survey conducted by Louis Harris Associates, sponsored by the Common-

wealth Fund, of older adults. What we have learned from this survey is that about 20 percent, or 1 in 5, of older adults are in fair or poor health, and that is greater among the nonworking population, those who have retired or left a job. One in three of those are in fair or poor health. We have learned that older black adults are twice as likely to be in poor health. Low-income people are six times as likely to be in fair or poor health as very high-income people.

We have also learned quite a bit about health insurance coverage of this population, and as I said, loss of insurance for this group, because of the end of a job or retirement, can be very serious, because once an individual has a preexisting health condition, private health insurance coverage may not be available at any price. Care for that condition may be excluded or have a long waiting period, and premiums can be quite high.

Health insurance coverage is greatest for adults between the ages of 35 and 45. After that, the rates of uninsured begin to go up a little bit, so if we are talking about the older adult population, roughly 11 percent are uninsured.

About 44 percent of adults receive coverage from a current employer, while an additional 19 percent receive coverage from a former employer. About 15 percent go out and buy health insurance individually, and about 10 percent are covered under some other form. It is interesting, among the older adults, that only about 2 percent get covered under Medicare through its disability eligibility provisions.

One thing I would like to stress, it is just not the case that everyone gets retiree health benefits. We focused a lot on the unfunded liability of retiree health benefits. We tended to get an image that everyone, when they retire, get health benefits from a former employer.

In fact, only two-fifths of people not working have coverage from a former employer, and that is much higher among high-income people than low-income people. Therefore, those who are not working or work part-time, what they tend to do is buy health insurance. If they get it, they are three times more likely to be buying it individually. Again, it can often be expensive or even unattainable.

If you look at the nonworking population, while I said overall, among older adults, 11 percent are uninsured, among those not working 17 percent are uninsured, compared with 6 percent of working adults.

Again, black and Hispanic older adults, while they are sicker, are much less likely to have health insurance, and are twice as likely to be uninsured as white older adults. And then again, income is very important.

Low-income older adults are 15 percent more likely to be uninsured. In fact, over half of low-income older adults are uninsured. I think one of the most disturbing findings from this survey is to find the link between poor health and gaps in health insurance coverage.

Almost 40 percent of people with no health insurance are in fair or poor health. And that is, of course, both because people in poor health are less likely to be working, and also less likely to be able to get private health insurance. Even among those who say their

health is poor or fair, only 6 percent are covered under Medicare disability coverage.

So, I think there are a lot of problems with this group. We know that many of them are sick, many of them have low incomes, and have difficulty getting coverage, either from a former employer or through individual coverage.

Well, what could be done about it? What I set forth in my testimony are some options to permit older adults to buy Medicare. I think that is particularly important, because there are 2.4 million people in this age range with no health insurance.

There are about 4.3 million who are in fair or poor health. And there are about a million who are doubly vulnerable: They are currently in poor health and have no health insurance.

Anyone in poor health could become uninsured if they lose their coverage, for example, through the loss of a job. The potential at-risk population could be up around 6 million. One approach of assuring health benefits to older adults is to give them the option of purchasing Medicare. You could subsidize it or provide it on an unsubsidized basis.

If you provided it on an unsubsidized basis, the premium would have to be set high enough to cover costs; not just the average cost, but to take into account that probably sicker people would opt for this.

Another option would be to set a premium at an average health cost. That would require some subsidies, if, as you might expect, sicker people tended to take advantage of the buy-in.

One might argue that there is a case for providing such coverage on a subsidized basis. Beneficiaries who now turn age 65 have contributed something like 40 percent of the value of part A over their working life time, the rest picked up through employer contributions. Obviously, they pay 25 percent of the part B coverage through a direct premium.

One possibility would be to let older adults buy in and have them pay 40 percent of part A costs and 25 percent of part B costs. It is hard to say exactly what that would cost.

But if you took the average cost for all Medicare beneficiaries, age 65 to 85, you know, the older population, applied that to the somewhat younger population, you would be talking about having the beneficiary contribute $1,200 a year, roughly $100 a month, and it would require a subsidy of roughly $2,400 a year. So that is applying the average experience of a much older population to somewhat young population.

Those are some options for how you might set the premium. There are options for eligibility. Obviously, at one extreme you could simply permit all uninsured older adults to buy Medicare coverage, but I think people who now are buying individual private insurance might choose to drop that coverage and buy Medicare instead, so I think when you are trying to estimate how many people would be effected, it is important to include not only the uninsured, but people with individual insurance as well.

The broadest option I set forth, if you let everyone between the ages of 55 and 64 buy Medicare who is not covered under either a current employer plan or former employer plan to buy Medicare, you would be talking about 7.7 million older adults who are newly

eligible to purchase Medicare coverage, people who are uninsured, but also people who purchase insurance currently on an individual basis.

A more targeted approach would be to expand Medicare coverage to spouse and dependents of Medicare beneficiaries. It is somewhat of an anomaly, we encourage employers to cover not only their workers but spouses and dependents, but Medicare does not permit a spouse under age 65, or in the case of a disabled person who may have children, to purchase Medicare.

So if you opened it up to that population, there are about 600,000 spouses under the age of 65 who are not covered under an employer plan who might choose to purchase Medicare, and about 300,000 dependent children. So that is another group that could be brought in, Medicare spouses and dependents.

Another group would be to focus on the people who have taken Social Security cash assistance at age 62. Those who are age 62 to 64, they are retired for the most part, out of the workplace, getting cash assistance, but they are not eligible for Medicare—people don't understand that—until they are aged 65.

There are about 3.4 million people in that age range; about 12 percent are uninsured. About 20 percent of these cash assistance recipients are currently getting Medicare as disabled beneficiaries—again, not too surprising, because this is a very sick group. If you added it up, all the people between ages 62 to 64 who are getting cash assistance, who are either uninsured, buying coverage individually, you would be talking about a million older adults in that age range who might potentially opt for Medicare coverage.

If you wanted a still smaller group, one approach would be to waive the 2-year waiting period that exists for Medicare coverage as a disabled person. Once you qualify for disability insurance, there is an additional 2-year waiting period for Medicare coverage. So another approach would be to waive that 2-year waiting period for anyone who is on cash assistance at age 62.

All of these policy options deserve careful analysis and consideration to reduce the numbers of older adults at risk. Older adults would not be helped to any considerable extent by the policy proposals to expand health insurance coverage they are currently considering.

I talked specifically about extending Medicaid to all poor people, but many of these people have assets and will never be covered by Medicaid. They won't be helped. That would cause employers to provide health insurance to all full-time workers.

Therefore, more innovative policy approaches will have to be developed if older adults are going to enter into retirement with any genuine degree of financial security.

[The statement of Ms. Davis follows:]

UNINSURED OLDER ADULTS:

THE NEED FOR A MEDICARE BUY-IN OPTION

Karen Davis

Thank you, Mr. Chairman, for this opportunity to testify on the problems of uninsured older adults and the need for a Medicare buy-in option.

Policy proposals to improve health insurance coverage have focused on gaps in health insurance coverage of children and working families. However, a large number of older adults between the ages of 50 and 64 also face major problems as a result of inadequate health insurance coverage. These older adults include early retirees, those who become disabled or must leave their jobs for health reasons, those who are forced out of their jobs in later years through downsizing, mergers, or plant closings, and others who lose private health insurance coverage through divorce, or the death or retirement of a spouse.

This is a rapidly growing segment of the population, as the post-World War II baby boom generation matures. The higher rate of health problems leaves this group particularly vulnerable to high health care costs if they lose health insurance coverage. Insurance industry practices of excluding bad health risks or pre-existing conditions from individual health insurance coverage also increase the vulnerability of this population to financial hardship and inadequate access to needed health care services.

Today, I would like to present new information from a Commonwealth Fund commissioned nationwide telephone interview survey in 1989 by Louis Harris and Associates of women ages 50 to 59 and men ages 55 to 64. This survey provides insights into the health and socio-economic characteristics of uninsured older adults. Finally, I would like to suggest for consideration several policy options to expand Medicare buy-in coverage to selected groups of under 65 older adults.

Health Problems of Older Adults

The onset of chronic health conditions in older age results in a significant portion of the older adult population with fair or poor health. The prevalence of fair or poor health triples after age 45, with 17 percent of adults between the ages of 45 and 64 in fair or poor health compared with 5.5 percent for younger adults. Not surprisingly, the proportion of the population in fair or poor health continues to increase after age 65, with 29 percent of elderly people in fair or poor health. Across all age groups, the biggest shift toward fair or poor health takes place in later middle age.

Wide differences exist, however, in health status based on working status. For example, one in three older adults who are not working are in fair or poor health. Non-working older people are more than three times as likely to be in fair or poor health as are full-time workers.

The relationship of health status to work status is not surprising. Those individuals who become ill, suffer from chronic conditions, or become seriously disabled are most likely to leave their jobs for health reasons. Individuals in fair or poor health may have a harder time finding employment if they become unemployed. Further, even among those who desire to work, those in fair or poor health may only be able to work part-time.

The rate of fair or poor health does not differ markedly by sex -- twenty percent of both older men and older women are in

fair or poor health. Particularly noteworthy is the finding that unmarried individuals -- those who are divorced, separated, widowed, or never married -- are more likely to be in fair or poor health than are married older adults (25 percent vs. 19 percent).

Health status varies by race and ethnicity. Older black adults are twice as likely to be in fair or poor health as are older white adults (36 percent vs. 18 percent). Older Hispanic adults are slightly more likely to be in fair or poor health than are whites (21 percent vs. 18 percent). These racial and ethnic differences are consistent with extensive data showing that mortality and morbidity are much greater among minority populations. These differences are partially a reflection of income and occupation, but may also reflect differences in access to health care, health habits, discriminatory barriers to health care, or other cultural factors.

Economic status is strongly linked to health status. Lower income people (with family incomes less than $7,500) are six times as likely to be in fair or poor health as very high income people (greater than $50,000 family income). In fact half of all lower income older adults are in fair or poor health.

Health Insurance Coverage of Older Adults

The greater risk of poor health among older adults also means that older adults are at risk for higher health care expenses. Insurance coverage for this age group, therefore, is especially critical. Loss of insurance through early retirement or unemployment can mean exposure to quite burdensome health care bills. Further, once an individual has a pre-existing health condition, private health insurance coverage may not be available at any price, or care for that condition may be excluded from the plan.

Health insurance coverage is greatest for adults between the ages of 35 and 45. The proportion who are uninsured then increases slightly in older middle age. About 11 percent of older adults between the ages of 50 and 64 are uninsured. Forty-four percent of older adults receive coverage from a current employer, while an additional 19 percent receive coverage from a former employer. About 15 percent purchase health insurance individually, while about 10 percent are covered from some other source such as spouse's employer. Medicare covers only 1.7 percent of older adults under its disability eligibility provisions.

Work status is one of the most important determinants of health insurance coverage. This is not surprising given that the most common way in which working age adults receive health insurance is through an employer. Contrary to popular opinion, those who are not working do not typically receive coverage from a former employer. Only two-fifths of those who are not working receive coverage from a former employer. Retiree health coverage is limited, and affects primarily higher income individuals. For example, half of non-working older adults with incomes over $50,000 receive health insurance coverage from a former employer, compared with 17 percent of non-working older adults with incomes under $7,500.

People who are not working or who work part-time are more than three times as likely to buy individual private health insurance as are full time workers. About 24 percent of those not working buy health insurance individually. This coverage, however, can often be quite expensive -- and even unattainable if the individual has a chronic health condition or prior poor health history.

Despite the greater rates of self-purchased health insurance and health insurance from a former employer, it is still the case that those outside the work force are the most likely to be uninsured and vulnerable to high medical expenses. Seventeen percent of non-working older adults are uninsured compared with 6 percent of working older adults. That is, non-working older people are more than two and one-half times as likely to be uninsured as are full-time workers.

Marital status is an important determinant of health insurance coverage. Unmarried older people are nearly twice as likely to be uninsured as married people (17 vs. 9 percent). Women are 20 percent more likely to be uninsured than men.

Health insurance coverage is strongly related to race and ethnicity. Even though Black and Hispanic older adults are in poorer health and in greater need of health insurance coverage, they are much less likely than white older adults to have health insurance coverage from any source. Black and Hispanic older adults are twice as likely to be uninsured as are white older adults.

Income is also an important determinant of health insurance coverage among older adults. Again, those with the poorest health and in greatest need of financial assistance to obtain needed health care services, are the least likely to have health insurance coverage. Low-income older adults (with family incomes less than $7,500) are 15 times as likely to be uninsured as very high income older adults (more than $50,000 family income). Almost half of low-income older people are uninsured.

Low-income older adults are much less likely to receive health insurance from an employer (13 percent of those with family incomes below $7,500 compared with 59 percent of those with family incomes above $50,000). In fact three-fourths of high income older adults receive health insurance from an employer or former employer compared with only one-fourth of low-income older adults.

One of the most disturbing findings is the link between fair and poor health and health insurance coverage. Almost 40 percent of people with no health insurance coverage are in fair or poor health, twice the rate for all older people. This reflects both the fact that people in poor health are less likely to be working and obtain employer-based health insurance and the fact that individual private health insurance plans often reject coverage for individuals who are poor health risks or have pre-existing health conditions.

About 6 percent of older adults in fair or poor health receive Medicare through its disability eligibility provisions, Medicare falls far short of covering all individuals under age 65 in poor health. In part this is a reflection of the two year waiting period for eligibility as a disabled person under Medicare. In part it is the restrictive test for disability that requires permanent and total disability before Medicare coverage can be extended.

Medicare Buy-In Option

The Commonwealth Fund survey sheds important new light on the health and health insurance coverage of older adults. Out of a population of 21.5 million older adults, 2.4 million people have no health insurance coverage. Over 4.3 million are in fair or poor health. Almost one million are doubly vulnerable -- they are in fair or poor health and have no health insurance coverage.

This understates the size of the most vulnerable population group, however. Any of the uninsured could become quite vulnerable if they were to experience serious illness. And any

of those in fair or poor health could wind up uninsured if they lose their employment or are denied coverage under an individual health insurance plan.

Medicare Buy-in Premiums

One approach to assuring the availability of health insurance of older adults is to give them the option of purchasing Medicare. The policy option of permitting adults under age 65 to purchase Medicare could be extended on a non-subsidized or a subsidized basis. For example, if older adults were charged a premium set high enough to cover costs, no subsidy would be required even if only those in fair or poor health opted for Medicare coverage.

Alternatively, buy-in premiums for older adults could be based on the average cost for older adults in average health. This would require some federal revenues to subsidize the premium -- if as seems likely the Medicare buy-in option attracts older adults in poor health.

Another justification for partial subsidy is the fact that Medicare currently subsidizes coverage for beneficiaries. While Medicare beneficiaries have contributed towards the program over their working lifetime by making payroll tax contributions, these contributions do not cover the full cost of Medicare. In fact beneficiaries' contributions over their lifetime covers only 40 percent of Medicare Part A coverage. Seventy-five percent of Part B coverage is financed by general tax revenues.

One possibility, therefore, would be for older adults to pay 40 percent of the cost of Medicare Part A coverage and 25 percent of Part B coverage -- extending the same subsidies to the under age 65 population as is currently extended to all Medicare beneficiaries. This would result in older adults contributing approximately $1200 annually, with the remaining estimated cost of $2400 per older adult supported by other Trust Fund and general tax revenues.

Options for Eligibility

If the option of purchasing Medicare were made available to selected groups of older adults, it might be anticipated that not only uninsured older adults but some older adults with individual health insurance coverage might opt for the Medicare buy-in. On the other hand retirees with coverage from a former employer or those currently working with employer-provided coverage are unlikely to pay the substantial premiums that would be assessed under any alternative.

One of the broadest options, therefore, is to permit buying Medicare coverage by all older adults over, for example, age 55 who are not covered under an employer or former employer health insurance plan. This would expand the option of Medicare coverage to an estimated 7.7 million older adults between the ages of 55 and 64.

A more targeted approach would be to expand Medicare coverage to spouses and dependents of Medicare beneficiaries. Currently, Medicare eligibility is only open to persons age 65 and over and to those who have been permanently and totally disabled for two years or more. Unlike employer health insurance plans that typically provide the option of coverage for spouses, Medicare does not permit under age 65 spouses of Medicare beneficiaries to obtain coverage under Medicare. It is estimated that 0.6 million spouses and 0.3 million dependents of Medicare beneficiaries are either uninsured or purchase health insurance individually and might opt for coverage under Medicare, if available.

Another group that could be brought into Medicare coverage are those individuals who have retired early and receive Social Security cash benefits at age 62. Approximately, 3.4 million individuals between the ages of 62 and 64 are receiving Social Security cash assistance. About 12 percent, or 0.4 million of these individuals are uninsured. Twenty percent of these individuals qualify for Medicare as disabled individuals. About 2 percent have Medicaid, but not Medicare. About 17 percent purchase coverage from individual health insurance plans. About half have coverage from an employer plan -- either as a retiree or through a spouse's coverage. Permitting Social Security cash assistance recipients who are not covered under employer plans to purchase Medicare could extend coverage to an additional 1.0 million older adults (those who are currently uninsured, buying individual coverage, or covered under Medicaid).

A still more limited step would be to eliminate the two year waiting period for coverage of the disabled under Medicare at age 62. This would assist those older adults who must retire early for health reasons, and for whom the wait for health insurance coverage can be especially serious as they face sharply reduced income and great health expenses.

All of these policy options deserve careful analysis and consideration to reduce the numbers of older adults at risk. Older adults would not be helped to any considerable extent by the policy proposals to expand health insurance coverage that are currently being considered -- namely expanding Medicaid to all poor people and requiring employers to provide health insurance coverage to all full-time workers. More innovative policy approaches will have to be developed if older adults are to enter into retirement with any genuine degree of financial security and assured access to needed health care services.

The author wishes to thank the Commonwealth Fund, Louis Harris and Associates, and ICF Incorporated for access to the Louis Harris and Associates 1989 Survey of Older Adults and to William Custer, Employee Benefits Research Institute for tabulations of health insurance coverage of Social Security cash assistance recipients ages 62 to 64, and spouses and dependents of Medicare beneficiaries from the 1988 Current Population Survey. The views expressed, however, are those of the author and not necessarily of these organizations.

Chairman STARK. Thank you. If you could stay with us for a couple minutes, Karen.

I would like to, without objection, introduce at this time Senator Akaka, who was unavoidably detained, and ask him if he would like to present us with his brief statement. Also he wanted to introduce one of our witnesses.

Dan, welcome. It is good to see you. Would you like to take a seat? Proceed in any manner you are comfortable.

STATEMENT OF HON. DANIEL K. AKAKA, A U.S. SENATOR FROM THE STATE OF HAWAII

Senator AKAKA. It is great to be back to this side. I want to thank you and the members of your committee for this opportunity to appear before you, and to discuss health care in Hawaii.

The State of Hawaii has always been at the forefront of innovative approaches to guaranteeing health care coverage to its citizens. We believe that every individual has a right to basic health care. That is why in March of this year, Hawaii became the first State to make universal access to health care benefits a reality.

Hawaii has achieved this status through a network of three major health care programs. The first is the Hawaii Prepaid Health Care Act which was adopted by the State of Hawaii in 1974. This landmark legislation now covers 88 percent of our population and requires employers to provide certain minimum health care coverage for their employees.

The second is the State's Medicaid program, which uses Federal and State funds to guarantee access to care for the 7 percent of the population at the bottom rung of the economic ladder.

The third is the new State health insurance program, or SHIP, as it is now known, which provides basic health care services to the remaining 5 percent of the population ineligible for either prepaid health care or Medicaid.

Maintaining this innovative health care network has not always been easy, and the Federal Government has sometimes been the greatest obstacle to universal coverage. As evidence of this, I point to the State's experience with the Hawaii Prepaid Health Care Act.

In 1980, the Ninth Circuit Court of Appeals held that the preemption clause in Employment Retirement Income Security Act of 1974 (ERISA) prevented the State of Hawaii from enacting minimum health care requirements for employers governed by ERISA.

The court determined that in the absence of an express exemption for the Hawaii statute, Federal law governs. The U.S. Supreme Court affirmed the lower court ruling, and concluded that relief could come only from Congress.

Soon thereafter, I sponsored legislation to grant an exemption for the Hawaii statute. After considerable debate in Congress, a limited ERISA exemption was signed into law, which allowed Hawaii to require employers to provide prepaid health care insurance. However, the exemption was not prospective. It only permitted the State to require the specific benefits set forth in its 1974 statute.

An unfortunate consequence of the Federal enactment has been that the Hawaii Prepaid Health Care Act has been "frozen in

time," as of January 14, 1983, the date the ERISA exemption was signed into law. There is an urgent need to bring the State statute up to date, for there have been no amendments since the State's 1974 statute was enacted.

In an effort by the State of Hawaii to require additional benefits—in vitro fertilization, mental health coverage, alcohol and drug abuse treatment, and child health supervision, commonly known as well baby care—without amending the Prepaid Health Care Act, the State has been using creative approaches as requiring such benefits through its insurance code.

However, since the State insurance code applies only to health insurance carriers and mutual benefit societies, these added benefits are not required of all employers. The Federal restrictions in ERISA prevent the State from keeping pace with current health care needs, and produces an inequitable patchwork of health care coverage.

Mr. Chairman, it is wrong to prevent a State that has been at the forefront of enlightened approaches to health care from making changes which broaden essential areas of coverage. Hawaii should not have to resort to back-door approaches in order to extend basic health care to its citizens. If anything, Hawaii should be rewarded with a broad ERISA exemption, rather than penalized as is now the case.

That is why I am introducing legislation today to provide Hawaii with a full ERISA exemption. This legislation will permit the State to rectify inconsistencies and generally upgrade the current scheme of health care benefits. Under my bill, provisions of State law adopted in 1974 can finally be updated for the 1990's.

Hawaii has a substantial investment in its prepaid health care law, and once it is given the flexibility which my bill would provide, its provisions will serve as a model for the State and Federal Government in the field of health care.

Chairman Stark, I now have the pleasure of introducing to you and other members of the subcommittee Dr. John Lewin, director of health for the State of Hawaii.

Dr. Lewin was appointed by Gov. John Waihee to head the department of health in 1987. He is of Navajo decent, and began his career with the Indian Health Service. He has also been an effective advocate for Native Hawaiian health initiatives.

Prior to his current position, he was director of the Kula Hospital, a State community hospital.

Dr. Lewin's goal is simple: to make Hawaii the healthiest State in the Nation. We are already part way there. The residents of Hawaii have the longest life expectancy of any other State.

Under Dr. Lewin's leadership, Hawaii has established the State health insurance program (SHIP) which is designed to provide basic insurance coverage to those who are not able to qualify for Medicaid, do not have employer coverage, and cannot afford the cost of an individual health insurance policy.

It is as a consequence of his leadership that Hawaii has set such a fine example in the field of health care. And I understand that you will include Dr. Lewin in a panel later.

Chairman Stark. We certainly will. If you don't stop soon, you will be in trouble convincing the good residents of Oakland, Calif.,

that it really is the only place in the world that is nicer than Hawaii. I keep reminding them of that.

Senator Dan Akaka, thanks. I think your request about ERISA and the path you are following would find strong support in this committee.

Mr. Gradison and I introduced legislation that would have allowed this. While there may be a great jurisdictional battle, we really feel that an ERISA was never intended to cover health insurance, and while there are many that would like to keep it, it does cause more problems than it perhaps solves.

I hope you are successful. I certainly would continue to work to see a much bigger opportunity for exemptions for good causes. I thank you.

Senator AKAKA. Thank you very much, Mr. Chairman, and Will Gradison and members of the committee.

Chairman STARK. Thanks very much.

Now, without objection, I think we will proceed with Dr. Davis. Mr. Gradison, would you like to inquire?

Mr. GRADISON. I am just reflecting, Mr. Chairman, on the excellent testimony we just received from Senator Akaka, which suggests to me, that at least one State thinks it can deal with this problem without coming hat in hand to Washington. Maybe it is the only State that can do it. Maybe all States can do it.

I multiplied out, and I might have missed a decimal point here, Ms. Davis, $2,400 times 7.7 million older adults, and I got $18.5 billion. Does that sound about right?

Ms. DAVIS. That is about right.

Mr. GRADISON. That takes care of that issue. I do want to ask you, though, in seriousness, in terms of priorities, recognizing we can't do everything at once, if we were going to take a major step forward in filling some of these gaps through Federal actions and had *x* billion dollars available, would you really start with this group or would you do it with kids, first?

Ms. DAVIS. I certainly applaud what the Congress has done with regard to expansion of Medicaid coverage with regards to low income children. I think the action in 1989 of covering people in the poverty level is a fine step. On the other hand, many of the younger group don't have very serious health problems, except for the very poor.

Gaps in health insurance coverage are potentially a problem for everyone. If you are talking about a very sick, very disabled population, you can have a heart attack, a stroke, cancer, you are talking about bills that are going to run $20,000, $50,000. Somebody who has worked all of their life may be self-employed and then becomes disabled with heart disease and can't continue to work, is going to be wiped out totally by that. And, unfortunately, somebody, once they have a health problem, would find it very difficult to get coverage to cover that.

I think in terms of financial burden, in terms of the potential risk that insurance is supposed to solve, that that would be a very high priority group to address.

Mr. GRADISON. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. I think Bill's arithmetic is right. I guess the issue is, of the $18.5 billion, what is the necessary social cost? In other words, while it would cost us $18.5 billion to provide the Medicare coverage, what are we losing now in uncompensated costs? Or what are we losing in Medicaid costs in some cases?

Ms. DAVIS. I think, for example, one in direct effect is once these people are bankrupt, they are going to qualify for Medicaid, Social Security income, so you are going to have to support in many cases a widow, particularly after the death of a spouse.

Chairman STARK. We saw in Spencer Rich's article Monday that in the District, there is 110,000 uninsured, according to his figures, and the hospitals in the District of Columbia are saying that this costs them $176 million in uncompensated care costs.

Now, if all 110,000 are under 65, and my figures of $1,000 are right, we would save $66 million, socially.

Ms. DAVIS. Right.

Chairman STARK. The system would save it. On the other hand, if the 110,000 are all in the age groups that you are talking about, we lose some, and I guess we just don't know. If we could break that 110,000 down, we would have a better idea, but I guess at some point we make the transfer. For a long time we have been transferring the cost of these people to private industry. We have been transferring the cost to States. We have transferred the cost to revenue.

If we suddenly talk about transferring it to taxpayers, one way or the other, and take it off the others, there will be a change of burden. I think it would be fairer to spread the cost. I am indifferent as to whether we could spread it statewide or nationwide, if all the States would do it.

I appreciate your bringing the problem to us. I have some examples, and I am sure we all get them in our congressional offices, of people who are very ill. The letter I want to put into testimony is written by a woman who has had amputations because of diabetes, and has a heart condition, and she was at one time with Travelers. Her husband was covered by the Railroad Retirement Act and she didn't qualify because she didn't have enough quarters for Social Security. So she is 62 and, arguably, very sick, and no one is going to cover someone with a heart condition and diabetes. But somebody, I suspect in Castro Valley, maybe even Eden Hospital, is probably going to end up with her as an emergency patient and pay the bill. So it gets done. It just gets done very unfairly.

I hope we can figure out a way to solve this problem. Some States have done it and we will hear about that shortly.

Thank you.

I guess you can find more information about the social costs. If so, how can we get from the economist the answer to my question so I could respond to Bill Gradison's question? Guess what, it is going to cost us $18.5 billion. And who is already paying this bill? Then we should begin to see where the winners and losers are and what we should do.

Ms. DAVIS. I would say I put that forward as the outside range of what one might do. If you initially opened it up to everyone over age 55, and if in fact that group, while they have got some sick people, probably won't average as high a cost as the elderly popula-

tion, but what I set forth, the continuing of options of focusing on a much more limited population who are cash recipients between the ages of 62 and 64, you can even waive the 2-year disability. You would probably be talking about 75,000 people, instead of 7.7 million people if you started with that.

I don't want you to think the only thing you can do is—there is a way of helping the very needy who would qualify for disability, but are in that 2-year waiting period. Then you are talking about a much smaller population group, and certainly one that would probably fit some of the examples you are talking about.

I think the Washington Post article mentioned the self-employed painter, age 61, his insurance company went out of business. He was uninsured. He had a heart attack—$40,000 worth of savings down the drain. Had to sell his business. Never thought he would be poor at the end of his lifetime. It is that sort of situation, I think, having some kind of form, some options for buying in to Medicare.

The other option, of course, is simply subsidize it less, to make it available at a higher premium. Again, that is very hard because some of these are kind of lower income working families who couldn't afford the full cost of $3,600.

Chairman STARK. There is something lacking where Medicaid kicks in, and that, I think, gives us another crack that a lot of people fall through. Most just never quite spend down to the Medicaid level until there is a real disaster.

Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Dr. Davis, did you just cite some statistics about how many people would be involved in expanding the Medicare program if you were to waive that 2-year period?

Ms. DAVIS. My estimate is in the first year, you would have about 75,000 disabled people currently getting disability insurance, but not getting Medicare because they are in that 2-year waiting period for Medicare coverage. So they are between the ages of 62 and 64. They are getting disability insurance. They are not covered by Medicare because they haven't met the 2-year waiting period requirement.

Mr. COYNE. Do you have any estimates what that would cost?

Ms. DAVIS. Again, you are talking about roughly $2,400 a person to cover that group.

Mr. COYNE. What is the cost if we don't do it? Is it your sense these people don't seek medical care as a result of not having coverage, and then when they eventually do seek medical care, they are much sicker, and as a result it costs more to treat them?

Ms. DAVIS. That is right. What I am concerned about, this is a population with chronic health conditions. The diabetic that Congressman Stark mentioned, somebody with heart disease, somebody with hypertension, if they don't keep the blood pressure under control, the diabetic condition under control, you will get to an amputation, you will get to a stroke situation that will have even higher cost.

For older people with these chronic conditions, it is very important they be in ongoing care to keep conditions under control before they result in catastrophic health events that both, the

human tragedy is a significant one, but also in terms of medical expenses, dependency costs are very high.

Mr. COYNE. Thank you.

Chairman STARK. Ms. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

I just wanted to welcome you back, Ms. Davis. It is very nice to have you before us again and to hear your thoughts on some of these issues.

I was interested by your comments in your testimony that the expansions could be subsidized or not subsidized, and I think that is an important comment, because some of the groups that you are referring to really need access, particularly with the number of mergers and things like that that promote unsolicited early retirement and expose not only workers but their dependents to a perilous absence of health insurance.

But the issue of cost and what kind of premium it would take for them to completely carry their weight under Medicare, is not an issue you directly address. You do remind us of the percentage of cost that current participants in Medicare cover, which is not impressive. Essentially, to expand Medicare, individuals would pay only 40 percent of part A and 25 percent of part B if their payments equaled what today's beneficiaries pay.

What kinds of premiums would be associated with 100 percent coverage of Medicare benefits and how would those relate to private sector premiums?

Ms. DAVIS. It is difficult to get a good estimate on that because of this issue of adverse risk selection. It is hard to know when everyone would come in who was uninsured, or whether just those who are very sick. And if so, but the 3600 that I have put in my testimony is the average total cost of part A and part B for the average Medicare beneficiary, who now, of course, is over age 65, or disabled.

Now, I have looked at some figures, for example, of the Medicare beneficiaries between the ages of 65 and 69. Their expenses are about 20 to 25 percent below that. In other words, this very high average cost, because you have got 85-year-olds and some very frail people in Medicare.

If you are looking at a population 62 to 64, in general, you would think that cost of people 65 to 69 would be fairly close to what it would run for that population group. So I would say the $3,600 is about 25 to 30 percent too high for someone of average health between the ages of 62 and 64.

On the other hand, what we know is that the uninsured, those who are retired and taking cash assistance, are disproportionately sick, so you then might have to raise the premium 20 to 25 percent to have it nonsubsidized, so you might wind back up to this total cost of $3,600, which I was suggesting $2,400 might be paid by the beneficiary.

In terms of private health insurance and what it would cost one of these older, 62 to 64, individuals to buy private health insurance, first of all, the issue is many of them can't get it if they have a preexisting health condition, if they are bad enough risk, or it may have a 2-year waiting period on a preexisting condition. But to give you some sense, if you were of average health and you were be-

tween the ages of 62 and 64 and you lived in a medium-cost area of the country, you would be talking about private insurance premiums that run on a monthly basis anywhere from about $200 to $225, in that range would be a monthly premium cost.

So the quotes that I was giving you for Medicare are 294, that is again assuming the over-65 population, not the 62 to 64, but average health, average cost area. Somebody 62 to 64, going out and buying private health insurance, they are going to be spending about $2,500 a year for that coverage, and it will have deductibles and coinsurance the way Medicare does, as well.

Mrs. JOHNSON. One other point I think that is very relevant here, Medicare is an open-ended program. I mean you can get almost anything you want under Medicare.

Recently, in Connecticut, they did a study in preparation for some reform legislation that we considered. We are a very high mandate State, so they were looking at what it would cost to provide insurance to small employers for their employees under State mandates versus under a waiver of mandates for specific programs that could be offered by the private sector. They examined several programs: a program that would be 50 percent of premium under mandates, a program that would be 60 percent of premium and 70 percent of premium, and 85 percent of premium, and it was very interesting.

Is anyone doing any work about options so that buy-in for dependents who are under 65 would be for less than the full range of services, but at least would provide preventive ordinary treatment, no hospital coverage, physician coverage with copayments, but a smaller package? Because currently under Medicare, there are no restrictions at all, and one can make a case that you would reduce the cost of Medicare if you drew some lines that would effect very few.

Is there an option to buy in to Medicare that would involve buying in a lesser package? Because that would definitely reduce costs.

Ms. DAVIS. I think that is an issue to look at. If you look at the Medicare benefit package, I think some beneficiaries would quarrel whether it is open ended. Actually, it has a very limited mental health benefit. For the most part, it doesn't cover prescription drugs outside the hospital setting, has very limited preventive care coverage. The Pap smear has just recently been added to coverage. Check-up for an elderly person, in the absence of symptoms, won't be covered.

I think when you get down to it, the Medicare benefit package is basically hospital services and physician services. It has some home-health benefits, but that is limited.

Mrs. JOHNSON. I was thinking about it in terms of surgical options, appropriate or inappropriate. You are right, in a way it is very limited.

Ms. DAVIS. There is a $600 deductible on the hospital side, which I think is very high.

You mentioned Connecticut law. I thought there were some interesting things in that. I thought particularly trying to reduce the cost of the plan to small business, by letting them use Medicare payment rates.

Mrs. JOHNSON. I would caution you in looking at the Connecticut plan to look very carefully at it, because although their organization proposal was to reduce cost by providing options and coverage packages, all of the savings are the consequence of a decision to reimburse providers' at 75 percent of Medicare reimbursement.

We know from Medicaid that this is a steep, slippery slope to bankrupting providers, so it is not a program that has many years to live. It is a program that you are going to need to come back to. It has got some real strong parts to it, but ultimately this issue of overriding mandates, going around them as companies have done through ERISA, is an issue we will have to address if we are going to provide the variety of options we need to make insurance affordable.

In this case you raise the Medicare buy-in. It might be more appropriate, particularly for dependents, to be able to buy into a more preventive package that provides better options for prevention and treatment, and maybe does have more exposure in some other parts, or limited use of certain other medical options.

Ms. DAVIS. I think the Medicare benefit package is a good one for older adults with chronic health conditions. They do have big hospital bills, repeated hospitalizations, need to keep on regular visits to a physician, and it is exactly those kinds of benefits the Medicare program does a good job of covering.

But I thought the example of using some of the cost control in Medicare is a very important one to extend it to this population group to let them take care of Medicare cost efficiencies provided by payment reform and enacted by Congress over time.

Mrs. JOHNSON. Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Welcome. I just have a couple of questions.

As I read your testimony, in terms of the uninsured older person, they are more likely to be women, right?

Ms. DAVIS. Actually, the rates of uninsurance don't differ that much by sex.

Mr. LEVIN. It says women are 20 percent more likely—

Ms. DAVIS. Right. They are a little bit higher.

Mr. LEVIN. And if they are unmarried, they are more likely to be uninsured than if they are married, right?

Ms. DAVIS. Right. They might have been covered under a spouse's policy, but if that spouse dies, you could lose coverage.

Mr. LEVIN. If they are black or Hispanic, they are twice as likely to be uninsured than if they are a white, older adult, right?

Ms. DAVIS. Right.

Mr. LEVIN. Maybe those data say something to us about the dynamics of this issue.

If you would, because I missed part of the testimony, just quickly sum up the cost if we took your suggestion in terms of the buy-in of part A and part B. In other words, they would pay just the portion that was not subsidized by general taxation.

Ms. DAVIS. Right.

Mr. LEVIN. What would it cost? Can you give us that figure?

Ms. DAVIS. Roughly, you are talking about the beneficiary paying $1,200 and the program subsidizing $2,400. If you are talking about

a million people who are now on cash assistance, between the ages of 62 and 64, uninsured or buying, basically you are talking about $2.4 billion for that group, but even with that, you could get to a smaller subset, for example, the disabled who are on disability insurance but not yet meeting the 2-year waiting period for Medicare, about 75,000 people. You could cover a million, or do a much more limited group within that.

Mr. LEVIN. If we covered the million, to the extent General Treasury funds cover those already under Medicare, we are talking about $2.5 billion a year?

Ms. DAVIS. Roughly, right. Again, I think that is on the high side since I am using the average cost for all elderly.

Mr. LEVIN. Thank you.

Chairman STARK. Karen, thank you very much.

Ms. DAVIS. Thank you.

Chairman STARK. Our next witnesses are a panel consisting of Dr. John Lewin, director of the Hawaii State Department of Health, Honolulu, Hawaii; James Hooley, commissioner, Massachusetts Department of Medical Security, Boston, Mass.; Dr. Robert Crittenden, special assistant for health to Gov. Booth Gardner of the State of Washington; and Dan E. Beauchamp, deputy commissioner of the division of planning, policy and resource development, New York State Department of Health, Albany, N.Y.

Your prepared testimony will appear in the record in its entirety. In whatever manner you would like to expand on that testimony or enlighten us further, please proceed.

If you want, please start in the order that I called you, Dr. Lewin, Mr. Hooley, Dr. Crittenden and Dr. Beauchamp.

Dr. Lewin, lead off.

STATEMENT OF JOHN C. LEWIN, M.D., DIRECTOR, HAWAII STATE DEPARTMENT OF HEALTH, HONOLULU, HAWAII

Dr. LEWIN. Thank you, Chairman Stark, members of the Subcommittee on Health. Senator Akaka did give a little bit of background.

Hawaii has some very positive health statistics and health status data. Hawaiians not only have the greatest longevity, but smallest premorbidity from cancer, heart disease and emphysema, and also the lowest health insurance rates.

We believe this is 10 years of access to primary care for almost all the citizens of Hawaii. We also were the first State to implement a health care system for the GAP group.

I think our distinguished colleagues here at the table have some very interesting programs to share with you as well. Hawaii implemented outpatient surgery, reduction of hospital stays, and some interesting programs in terms of community care services for the elderly at a very early stage, as well, and that has reduced health care costs in Hawaii.

And this may be of interest to you, in terms of the fact we have by far the lowest per capita long-term care bed ratio of any of the States in America, and that is also due to the access of primary care for our senior citizens.

The Hawaii experience—I think the big point I would like to make—the testimony is on record—Hawaii's experience is applicable to other States. I am very frequently confronted with the notion we are a tropical paradise.

Chairman STARK. Don't need shoes or houses.

Dr. LEWIN. We climb the coconut palms, but we have got our cellular phone with us. We do have a developed care system that concerns us, like the rest of the Nation. We do have a very comparable small business——

Chairman STARK. How many MRI's do you have in the State?

Dr. LEWIN. At the present time, we have two, and we are going to expand to seven.

Chairman STARK. You are going to ruin my anecdote. You currently have fewer than North Dakota.

Dr. LEWIN. We have done fairly well with two, thus far. Although because of the Island State's nature, we will probably have to have an MCI on each of the neighboring islands, as well.

We did have 17 percent uninsured 10 years ago, when the Prepaid Health Care Act came into being. Hawaii's economics, small business, large business, is very comparable. The Prepaid Health Act changed our uninsured to 3 to 5 percent.

So, I want to make the point, Hawaii has very applicable health statistics. I have lived in California and Arizona, and worked in those States as well, and it is comparable. Hawaii's whole model has been based on primary care and prevention.

We have the same issue of spending all of our money on illness and disease, rather than primary care and prevention, but the design for the future has been in that, and that is the key to, I believe, some of the present successes we have, and this relates to Medicare as well, in terms of preventing disease for the elderly, obviously, and it will be of interest to this committee.

I think another big issue that will not just strike you from the testimony, Hawaii has achieved community-based ratings for individuals in small businesses by pooling all those people together, and this happened without legislative mandate. This happened quite naturally when the Prepaid Health Care Act was implemented.

In 1978, there was a huge pool of people that were uninsured, and those people suddenly entered the insurance market. The insurance companies went aggressively after them and competition forced the rates down to the point the average small business person, under 55, cost $90 a month for comprehensive insurance.

The Prepaid Health Care Act is a very comprehensive—it is not minimum benefits, it is very comprehensive in terms of benefits offered to every citizen and dependents, covering 88 percent of the population.

I think the community-based rating issue is very important, because incremental additions of people under the insurance pool will allow the insurance industry to keep the rates high and continue with experimental ratings. I think America needs to learn with this.

The Hawaii Prepaid Health Care Act says smallest business has to have health insurance. The two big programs, obviously, the Prepaid Health Care Act and the new State health insurance pro-

gram, other than our Medicaid option, which other States have as well, have really given us this primary care access.

The prepaid health care program that Senator Akaka mentioned, needs to just be stressed, I think it is well-stated in the testimony in terms of the factors of the program, it covers everybody 80 percent—all the employed persons, and their dependents, and it is about a 60-40 split in cost between employer and employee.

The new State health insurance program, the GAP program, is a basics benefit plan. It doesn't cover hospitalization after 5 days hospital coverage, it is all primary care and prevention; well-person visits, Pap smears, mammograms, all the preventive stuff completely covered, and 5 days of hospitalization, the benefit is cut off.

The reason for that is because the GAP group already gets the hospital care and the emergency room care, and we are all paying for that through our health insurance rates, and we didn't want to repay or double-pay for all those benefits, so we designed the GAP program, really, to cover prevention and primary care.

And I think that is the big—the big issue there that we would like to share. It is a low-cost program, about $50 per month per beneficiary, and that is mostly because it is primary care, prevention.

The suggestions we would like to make: One, eliminate the ERISA restrictions on State-mandated benefits. If we could move our ERISA situation from the 1974 level to 1990, we could add measles immunization, we could add mammograms and Pap smears to insurance.

We could save a lot of money and continue the experimentation. We would like to reform Medicaid. I think Dr. Davis talked about reforming Medicare, and we would support that as well.

We would like greater experimentation in Medicaid delivery systems, because we know we could do better. We would like to reduce the paperwork. We think fiscal base for reforms is very important, as well, and that means tax incentives for employers for offering minimum benefit coverage, increasing Medicaid reimbursement options, and continuing to fund Medicaid options for States, rather than enacting mandates.

We would really like to increase the notion of State latitude in program development and implementation. One of the great features of innovation and creativity in our country is we have a Federal system, but we also allow States to experiment in areas in which, in this case, I think we could come up with some very creative solutions to keep costs down, as Hawaii has done.

It is really interesting that Hawaii went ahead with universal access, not really for any other reason other than we feel it is a right of citizenship for all citizens to have basic health care benefits, but the economics really work out and are going to be greatly valuable to the rest of the country.

I am grateful for the other experiments in the other States represented here today, and others that are not here, and we hope you will continue to support significant State latitude in program development and implementation.

These principles, I think, in the next few years will give us a great national experience with which to look at other programs, and we very much appreciate the opportunity today to come in and

share with you our experience in the national health policy development.

Thank you very much.

Chairman STARK. Thank you.

[The statement and attachment of Dr. Lewin follow:]

STATEMENT OF JOHN C. LEWIN, M.D., DIRECTOR
HAWAII STATE DEPARTMENT OF HEALTH

Chairman Stark and members of the Subcommittee on Health, I wish to express my appreciation for the opportunity to contribute to national health policy development by outlining Hawaii's innovations in this area. We have had the good fortune to innovate largely because we have lower health insurance rates and that is largely due to 10 years of near-universal access to primary care. We deeply appreciate the opportunity and recognition you have given us by inviting us here today.

Hawaii is often thought of as a tropical paradise, one in which no one is sick, or one which is backward and undeveloped. A newspaper in Switzerland, for example, suggested last year that Swiss citizens would have to have cholera shots before entering Hawaii and to "be careful not to drink the water." On the contrary, no cholera shots are needed, the water is fine and we have one of the best basic health systems in the nation. Our system delivers high-quality care for low cost, despite our otherwise high cost of living. Hawaii also enjoys high-tech tertiary care programs as advanced as any state or nation. This has resulted in the lowest infant mortality rates in the nation, along with the lowest death rates from such chronic illnesses as cancer and heart disease.

The key, I would hold, to our success is our state's longstanding commitment to ensuring that basic health care is available to all our people and to its innovative health care community which has experimented with ideas like short hospital stays, outpatient surgery, and preventive health programs long before they became the norm on the mainland United States.

Likewise, our state has implemented a mandated employer benefits program, the only one of its kind in the nation, has developed the third greatest number of implemented Medicaid Section 2176 waiver programs in the nation and has recently put on the road our subsidized insurance program to offer coverage to those left in the gap between these other programs. These programs are not panaceas for the national crisis of the uninsured--and we don't take them as such. But, neither are they inapplicable to the people of California, South Dakota, New Hampshire, or any other state. I've come 5,000 miles to bring you the message: We have something of value to share and look forward to working with our partner states, each of whom has something to offer, to contribute to national policy in health care.

HAWAII PREPAID HEALTH CARE ACT

Let us first start off by exploring a few basics about the current structures in Hawaii's system. The Prepaid Health Care Act was adopted in 1974 to provide health insurance and medical protection insurance for most employees in the State. The Act is administered by the State's Department of Labor and Industrial Relations.

The Prepaid Health Care Law is the nation's first state mandated benefits plan. Virtually all employers are required to provide health insurance to their employees. Dependent coverage is optional. Costs are shared in this program. The employee pays up to 1.5% of monthly wages up to half the premium cost. The employer provides the balance. Dependent coverage is optional. Employers may provide benefits as outlined in the Act on a self-insured basis but are still subject to the requirements that those services be provided. Two basic plans are available, a fee-for-service plan and a health maintenance plan. The fee-for-service plan is the plan most used in Hawaii.

Exclusions

Some of those excluded from the provisions of the Act are government employees (who have their own plan), seasonal agricultural workers, real estate and insurance agents working on commission, individual proprietorship members in small family business, and government assistance program recipients.

Employee Eligibility

To be eligible for Prepaid Health Care, employees must work at least 20 hours a week and earn a minimum amount per month. The program is administered in conjunction with temporary disability and workers' compensation insurance and, so, no large state bureaucracy has been created to administer the provisions of Prepaid Health Care. An employer fund exists to assist employers who cannot, because of economic limitations, provide for the cost of the insurance, and to assist employees whose employers have gone out of business or who have not provided for the insurance.

COMMUNITY RATING FOR HEALTH INSURANCE

By requiring virtually all employers to provide insurance, Prepaid Health Care has permitted health care contractors to provide health insurance rates for small employers comparable to those enjoyed by large employers. This has happened because all small business now forms a large risk pool. Adverse risks are part of the overall pool, which eliminates the need for insurance companies to individually rate employers.

The results have been extremely positive. Small business can purchase insurance at reasonable rates. Employees are covered with health insurance. Insurance companies cut administrative costs and can market to a large pool of businesses. Prepaid Health Care has provided a uniformly level field for competition in which responsible small businesses who provide health insurance are not at a competitive disadvantage relative to those who do not.

MEDICAID

Hawaii's Medicaid Program services over 72,000 persons with a budget of about $220 million. It is administered by the State's Department of Human Services.

Hawaii provides Medicaid to both the categorically needy and the medically needy persons. Elderly and disabled persons with income up to 100% of the poverty level, and children under age 6 with income up to 133% of the poverty level are covered. We have chosen the option to provide coverage for pregnant women and infants with income up to the maximum allowed by statute (185% of poverty). We have also implemented the "presumptive eligibility" provision for pregnant women to encourage early prenatal care.

HAWAII POPULATION WITHOUT HEALTH CARE INSURANCE

The effects of these programs, particularly Prepaid Health Care, is evident. In 1971, a survey showed that those without hospital insurance were almost 12% of our population and those without physician insurance were over 17% of the population. The implementation of Prepaid Health Care showed a dramatic drop in those figures in several surveys conducted at the time. The Department of Health has estimated that those figures have grown with the shrinking of Medicaid to approximately 5% in 1987-1988 when planning began for the State Health Insurance Program.

Gap Group

Definition of Hawaii's "gap group" in need of care does not encompass the entire uninsured population. We have focussed on those people who have been uninsured by public or private health care coverage programs and who are at a low enough income level where they cannot access current health care insurance. The number is estimated to be between 30,000 and 35,000 people.

Populations at risk in the gap group are largely made up of those who, for one reason or another, lack access to Prepaid Health Care. As found in a 1988 survey, the unemployed make up over 30% of Oahu's uninsured. This is likely also true of the neighbor islands. Dependents of low-income workers, particularly children, are another major gap group. Part-time workers, excluded from Prepaid Health Care, are another population at risk. Neighbor island residents, immigrants, seasonal workers and students are also at risk, although they are not formally excluded from Prepaid Health Care.

STATE HEALTH INSURANCE PROGRAM

To meet the needs of this gap group, the State Health Insurance Program was implemented. The program provides universal access to basic health care services to all of Hawaii's people by building upon Hawaii's Prepaid Health Care Act and Medicaid.

SHIP has been created to subsidize affordable health care coverage, encourage usage of private insurance and Medicaid and to discourage shift to SHIP from private coverage. SHIP is thus designated as a partnership between government, individuals and families, and the private sector. Government subsidizes insurance coverage for those unable to pay. Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is essentially very similar to the model adopted by the State of Washington in its pilot Basic Health program.

Benefits

Benefits of SHIP are heavily weighted toward preventive and primary care, with health appraisals and related tests, well baby and well child coverage and accident coverage being covered fully. Twelve physician visits are made possible during the course of the year with a $5 co-payment. An individual's hospitalization, however, has been limited at up to 5 days with a dollar limit of $2,500. Two days is allowed for maternity care. As far as major exclusions, elective surgery, and high-cost tertiary care have been excluded. The program assumes that most members of the gap group will quality for Medicaid after exercising "spend down" for these costly procedures. Waiting periods exist for some conditions.

Costs

We estimate an average State subsidy to be about $500/year with an average share for each insured to run between $75 - $100/year. The insured share is based on a sliding fee scale where individuals will pay a portion of the cost on a monthly basis and will be billed directly by the insurance company for the monthly fee. This fee scale is based upon ability to pay. Co-payment at the time of visit is $5 and will be required for all subscribers.

Table A shows the monthly fee schedule which we have adopted for the State Health Insurance Program. Note that under 100% of poverty, there will be no monthly payments and payments rise so that, at 251 to 300% of poverty, most adults will pay for the entire costs of the insurance. Health care for children is still subsidized somewhat at that level. To be eligible for SHIP, you must be a Hawaii resident with gross income less than 300% less of the poverty level. SHIP eligibility is subject to enrollment and fiscal limits and must be renewed on a yearly basis.

SHIP CARRIERS

SHIP insurance is delivered through contracts with the State's two largest insurers--Hawaii Medical Services Association (HMSA), which has about 53% of all health insurance in Hawaii and Kaiser Permanente, which has about 15% of all health insurance in Hawaii. Both have been cooperative and enthusiastic about working with us in this program.

While the RFPs were issued to all insurance companies currently providing coverage under the Prepaid Health Care statutes (over 20 companies), HMSA and Kaiser were the only insurers to provide proposals at this time. The proposals differ from one another quite significantly.

Hawaii Medical Service Association

The Hawaii Medical Service Association contract covers the bulk of SHIP's subscribers. It is a fee-for-service plan, although we do propose that in the next year of the program some sort of a managed care system be developed--if not statewide, then at least to cover major areas of the state. About 700 physicians have signed on to participate in SHIP, through HMSA. This is almost one-half of all physician providers in the State. The contract is for statewide services. The insurance is as described in the Administrative Rules which have been provided to the Committee. One major facet of the insurance is that it does include a limitation of 20% of the total insurance dollar for inpatient hospitalization. We have worked with HMSA and most of the hospitals in the State to basically provide for at least some funding for inpatient care through this mechanism. The philosophy that we've adopted that currently the hospitals are providing for care for this group of people already--much of this is uncompensated. Any additional funding, even if it does not cover the whole cost of care, will be helpful to the hospitals in providing for their needs.

Kaiser Permanente

The Kaiser proposal is limited to 1,000 subscribers. Kaiser is willing to subsidize a portion of the costs of the coverage for their full health maintenance coverage for these persons. Services in the first year will be limited to the island of Oahu. The plan targets regular Kaiser members who lose their benefits, either through loss of Medicaid or loss of a job.

PROGRAM IMPLEMENTATION

SHIP was launched on April 16, 1990. Implementation was statewide. From the beginning, our objective was to eliminate the barriers and red tape which often deter the genuinely needy from getting government services.

Our major task has been to bring people into SHIP, to target what would be in any state perhaps the most difficult to reach persons, those people who are currently outside of the system. In this effort, we have emphasized the non-traditional.

We have, first, shortened application forms. These forms gather the minimum amount of information necessary to determine gross income, family size and basic information on each subscriber. Asset data is not collected. Second, we have a statewide toll-free telephone number available to persons who want to call and ask for information or application forms from SHIP. Third, certain categories of persons have instant access to SHIP, with no need to wait for SHIP's quarterly enrollment periods or less than the one-month period between enrollment and issuance of an insurance card. These persons are those dropping off the Medicaid rolls, pregnant women and children.

We have also developed a broad-based community outreach program. Over 200 volunteers have been trained to assist people filling out the SHIP application form. It might be noted that in our first weeks of operation, we've found that most of the forms that have been submitted have been complete and have been correctly filled out. We thus feel we're on the right track in developing a form that will eliminate at least the administrative barriers put in place by lengthy and complicated forms. Our volunteers have been enthusiastic and have been drawn from both Department of Health ranks as well as the ranks of private social service agencies and other community organizations, such as the Hawaii Public Health Association. This effort has transcended our regular organizational structure and has brought together a wide range of staff to work together in this exciting effort.

We have been flexible in our outreach in terms of trying to bring the program to the people. Application forms and assistance are available in many of the Department of Health offices statewide. Our goal is to make all offices enrollment centers. Special outreach tables have been set up at supermarkets, shopping centers, health fairs and other heavy traffic situations in the State. We have enlisted the five non-profit primary health care centers on Oahu to sign up persons for SHIP. We have also sent out "teaser" brochures to all 170,000 public school students in the State. These brochures inform parents about SHIP and provide a mechanism for additional information and applications to be obtained.

To further extend our efforts, we have worked very closely with our public agency partners--the Department of Human Services and the Department of Labor and Industrial Relations--in developing a referral system from these two major mechanisms to provide clients for SHIP. The fact that our three state level departments provide in a centralized manner the health and human services which are the purview of county and local governments in other states facilitates our task. All Department of Human Services eligiblity workers have been trained and are familiar with SHIP as well as many of those who provide for the unemployment insurance program in the Department of Labor and Industrial Relations. SHIP presentations are provided to the unemployed on a regular basis. Those persons who drop off of Medicaid rolls and those who enter the unemployment system are through this system provided access to SHIP.

Finally, we have developed an extensive media approach. Whether we like it or not, the media is the major way most persons receive information. We have utilized both free and paid media in our efforts to publicize SHIP. SHIP's opening press conference on April 16, 1990, was held by the Governor at a primary health care center. This attracted much media attention. Follow up telephone calls to "phone in" radio shows the following morning by the Director, Deputy Director in charge of the program, and the program administrator insured approximately 10

minutes of coverage for each of 15 stations located on all major islands. We have developed a television commercial and radio commercials in various languages which play frequently on a number of stations which have specialized listening audiences. This has kept costs down but allowed us to reach groups at particular risk of being uninsured. We have noticed in the SHIP office that minutes after the airing of commercials, our phone lines are jammed. This is true even after the commercials have been playing for three weeks. A SHIP video tape, 9 minutes long, has been produced and copies are available for outreach and office use. This tape describes the benefits in the plan and discusses all the basic aspects of the plan.

Print ads and bus posters have also produced for SHIP and we have been issuing a weekly press release giving weekend outreach sign-up locations. These have been picked up by the media and has been in the newspapers across the state every weekend thus far.

We're also part of a unique program which uses touchscreen computers to provide information and referral on state health and human services. This program entitled Hawaii Access is located at four locations on Oahu. We are developing a module which will allow people to actually apply for SHIP through this publicly accessible computer touchscreen.

What has all this effort resulted in? First, over 10,000 applications (which can enroll a whole family) have been mailed out or given out statewide, either through the SHIP office or as a part of our extensive outreach efforts. Over 3,500 applications have been received by SHIP and are currently being processed. Our enrollment period has been extended to deal with the flood of applications as well as to ensure that as many school-aged children as possible can be enrolled in time for school physicals and required immunizations prior to the start of school in the fall. As of May 25, 1990, 730 families were enrolled in SHIP or had only to pay their premium deposit in order to receive their insurance cards. On June 4, 1990, our first "SHIP baby" was born in Hilo, Hawaii.

CONCLUSION

We have, through Prepaid Health Care, expanded Medicaid options and our new SHIP offered Hawaii's people universal access to health insurance coverage. Our programs are not perfect. Because of the language of our ERISA exemption, we are unable to change our Prepaid Health Care program to bring it up to date with the needs of the 1990's and the future. Maximizing benefits for all eligible individuals is hampered because of the complex Medicaid requirements, and limited opportunities for State innovation. Medicare is beyond our direct capacity to influence, yet it provides for basic access to over 10% of our people. And SHIP is new--undoubtedly it will require many adjustments before it truly responds to the needs of our gap group.

As a state, we are proud to be able to contribute what we can to this national forum. As for our own specific recommendations to carry the nation through until consensus can be achieved on a national policy of universal access, we recommend four basic policies which will enhance the roles that states currently play in policy development. These recommendations would alter current Federal policies or programs which unduly inhibit state capacity for experimentation. We propose such flexibility, mindful of the memorable words of Justice Brandeis, "To stay experimentation on things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve

as a laboratory; and try novel social and economic experiments without risk to the rest of the country." We thus propose the following measures to enhance the respective state's capabilities to develop individual responses to the crisis of the uninsured:

1) Eliminate ERISA Restrictions on State-Mandated Benefits Plans

ERISA currently freezes the Hawaii Prepaid Health Care Law at the 1974 level. This impedes the growth of innovative measures such as cost containment, cafeteria plans, etc., as these would have to be developed within the parameters of the Prepaid Health Care Law. Eliminating the ERISA restriction will allow Hawaii and other states to experiment with mandated benefits and evaluate the results closely. For example, a state might wish to only mandate large employers to cover their employees and compare it with other states like Hawaii which have chosen to cover most of the employed persons within their boundaries. Similarly, the effects of various benefits packages could be studies with this increased state flexibility.

2) Reform Medicaid

The current Medicaid system is a patchwork of Federal mandates and options, linked together with heavy doses of administrative restrictions. States must wait years sometimes for waivers and changes in state plans must be approved by various HCFA offices. In order for Medicaid to be more responsive and flexible, we propose that:

A) Allow for greater state experimentation with Medicaid delivery systems. Such options as employer buy-ins and copayments which have been outlined in the policies of the Bipartisan Senate Committee could be tried in various states. Alternatives not yet conceived nationally might find fertile ground in one state or another.

B) Reduce administrative paperwork required for Medicaid. Many administrative requirements of Medicaid actually serve as barriers to the poor, be they working poor or truly indigent. If indeed Medicaid is to be a program for the poor, it must reach them. Major reforms which allow for state flexibility in this area should be enacted.

C) Create incentives for managed care alternatives under Medicaid. Very few managed care alternatives currently exist in Medicaid programs, and none at a statewide level. Fiscal and administrative incentives to offer such alternatives would help the spread of a more cost effective and responsible methodology of care.

3) Create a Fiscal Base for Reforms

While the large sums of Federal dollars needed to enact the bipartisan proposals do not currently exist, minor shifts of funds and incremental increases could provide the base for further increases at a future date. Such alternatives might be:

A) Provide a Federal tax incentive for employers offering minimum benefit coverage.

B) Increase Medicaid reimbursement levels for institutions and primary care providers,

particularly those in areas where there is a high proportion of uninsured persons. This temporary expedient could assist institutions impacted by large numbers of uninsured.

C) Continue to create and fund Medicaid options for the states rather than to enact mandates.

4) Allow for Significant State Latitude in Program Development and Implementation

The states remain inventive and important actors in this process by developing new models and systems of delivery, by sharing this innovation, states contribute to policy development. For example, SHIP has greatly benefitted from working with Washington State's Basic Health plan and a recent hospital subsidy program approved by our legislature is reviewing what Massachusetts had already done in that area. Even with implementation of Federal policies, the states should be given the flexibility to continue as major actors. Any future Federal health care legislation should be formulated on the basis that the Federal programs are safety nets and do not preempt state programs which seek to provide better benefits to their citizens. In fact, new Federal/State partnerships should be explored, such as possible joint projects for Medicare recipients. Through this principle, states can be encouraged to continue in the forefront of policy development in health care finance.

These principles, if implemented, should provide, over the next few years, for important national experience with many different alternative approaches to universal access or universal coverage. From this broad base, truly responsive and workable national policy can be derived, policy that will meet the important health care needs of America's uninsured without bankrupting America.

Thank you for the opportunity to contribute our thoughts on this vital national issue.

Table A

SHIP Sliding Fee Schedule

Family members	Annual gross income under	You'd pay monthly for each	
		Adult	Child
1	$7,224	$ 0	
	9,030	10	
	10,836	15	
	14,448	20	
	18,060	40	
	21,672	60	
2	$9,684	$ 0	$ 0
	12,105	10	5
	14,526	15	7.50
	19,368	20	10
	24,210	40	15
	29,052	60	20
3	$12,144	$ 0	$ 0
	15,180	10	5
	18,216	15	7.50
	24,288	20	10
	30,360	40	15
	36,432	60	20
4	$14,604	$ 0	$ 0
	18,255	10	5
	21,906	15	7.50
	29,208	20	10
	36,510	40	15
	43,812	60	20

SUPPLEMENT

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

HEALTH INSURANCE OPTIONS:
EXPANDING COVERAGE UNDER MEDICARE AND OTHER
PUBLIC HEALTH INSURANCE PROGRAMS

Date of Hearing: Tuesday, June 12, 1990

TESTIFIER:

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Major elements in Dr. John Lewin's presentation included discussion of the following topics:

- Provisions of the Hawaii Prepaid Health Care Law
- Community Rating for Health Insurance
- Medicaid
- Hawaii Population Without Health Care Insurance
- State Health Insurance Program
- State Health Insurance Program Carriers
- State Health Insurance Program Implementation

Dr. Lewin's statement recommended the following changes:

- Eliminate ERISA Restrictions on State-Mandated Benefits Plans
- Reform Medicaid
- Create a Fiscal Base for Reforms
- Allow for Significant State Latitutde in Program Development and Implementation

Chairman STARK. Mr. Hooley.

STATEMENT OF JAMES A. HOOLEY, COMMISSIONER, MASSACHUSETTS DEPARTMENT OF MEDICAL SECURITY

Mr. HOOLEY. Mr. Chairman, members of the subcommittee, thank you for inviting me to testify.

My name is James A. Hooley. I am commissioner of the Massachusetts Department of Medical Security, the agency which is implementing our State's universal health care law, which was adopted in 1988.

The department of medical security is a small agency, made up of hard-working professionals, and dedicated to the task of providing access to affordable health insurance for all our citizens.

As you may know, we have experienced some difficulties as we have progressed toward our goal. There have been attempts to delay and even to repeal this effort.

Last week, for example, the Massachusetts House adopted a budget amendment aimed at delaying the two principal mandates of the universal health care law by 2 years. I am confident that by the time the budget reaches the Governor's desk, the mandates basically will be intact.

But the point I want to make at the outset is this: The job of providing affordable health insurance is difficult and controversial. It brings with it critics who argue that the goal is impossible for a variety of reasons.

However, we have learned in Massachusetts that we can make substantial progress in spite of the controversy, because this problem demands a solution. It is so basic to all of us to have health and medical security that even our critics in Massachusetts have expressed qualified support for some of our programs. I think I know why. Because all of us know that we are just one serious illness or one job away from being uninsured ourselves.

Our program in Massachusetts is an incremental approach designed to focus, one by one, on each of the groups in our population that, for whatever reason, have gone without health insurance. We have been able to address some groups, like college students, quickly, because it was inexpensive and easily administered. Our more complicated efforts, major efforts like creating affordable health insurance products for small businesses and health insurance reform, will take longer.

But gradual and modest as our program is, by the end of this year in Massachusetts, there will be approximately 100,000 fewer uninsured persons in Massachusetts than when universal health care was adopted in 1988.

Just to comment on that, in our study we completed, we found about 7 or 8 percent in our population, about 5,000 Massachusetts residents are uninsured, so that puts it in context.

Our first program was Commonhealth. Primarily publicly funded, Commonhealth provides health insurance protection to four categories: Disabled adults who are working; infants and children with severe afflictions; pregnant women up to 200 percent of poverty; and persons on welfare who have found jobs that presently

do not offer health insurance. More than 18,000 persons have been assisted by the Commonhealth program.

In 1989, a provision of the Health Security Act became effective that requires all full-time college students in Massachusetts to either document that they have adequate health insurance through their parents' health plans or else purchase a plan at the institution they are attending. We estimate that some 50,000 students who previously were without health insurance are now insured under this provision.

Also, I might comment, this was a cost to us in the previous year of approximately $15 million in our free care pool.

Last year, we also initiated the Centercare program, a program that provides primary care to inner city residents through community health centers. More than 5,000 persons are enrolled in Centercare.

By the end of July, we expect to launch our program to provide basic health insurance to uninsured persons who are receiving unemployment benefits. This program is funded by an annual $16.80 employee assessment on employers of six or more persons. We expect around 30,000 persons to enroll in this program.

We recently launched our phase-in pilot programs which are designed to make available to small businesses adequate health insurance at affordable prices. This is an effort on our part to prepare employers for the principal mandate of the Health Security Act.

This provision requires employers of six or more, beginning in 1992, to provide health insurance worth $1,680 a year for each employee. We expect to have some 10,000 persons enrolled in the pilot programs by the end of this year.

As a part of our cost containment initiatives, our department has taken responsibility to manage the hospital uncompensated car pool in Massachusetts, a pool of private sector funds amounting to more than $300 million which provides payment to hospitals for bad debt and free care.

The Health Security Act also establishes a hospital conversion board to reduce excess hospital acute care capacity.

In addition to these initiatives, the department has conducted two important studies. The first one, already published, examines the special problems encountered by small businesses in the health insurance market. The second study, which will be published next month, details the problems and demographics of the uninsured.

These studies underscore a critical point: In addressing the twin issues of access and affordability of health insurance, it is absolutely essential that we initiate basic reform in the health insurance market as it relates to small business. To this end, the department of medical security has been working closely with insurers and the small business community to develop effective strategies for change.

Both of these issues—access and cost—obviously must be addressed. But we must not allow one problem to divert us from the other. We must not deny access to health care because of rising costs. The very suggestion that people should be denied health care because it costs too much is unconscionable.

Furthermore, if we deny health care to people because of cost, in the end we will find that the cost is higher, not lower. My experi-

ence in a previous position, as chairman of the Board City Hospital, taught me that.

We know, all too well, that delay of medical attention leads to higher cost, but it is not just for the individual, for the insurer. It is for society as a whole.

To turn away from the task of providing health insurance protection for all until we have health care costs under control just doesn't make sense. We have two problems here, access and affordability, and one feeds upon the other. We have to deal with both of them. And we have to deal with both of them now.

Thank you for your giving me this opportunity to testify. I would be pleased to answer any questions you may have.

Chairman STARK. Thank you, Mr. Hooley.

Dr. Crittenden.

STATEMENT OF ROBERT CRITTENDEN, M.D., M.P.H., SPECIAL ASSISTANT FOR HEALTH TO GOVERNOR BOOTH GARDNER, STATE OF WASHINGTON

Dr. CRITTENDEN. Thank you, Mr. Chairman, and members of the committee. It is a pleasure to be here, and also to be joined by these different States. It is also very heartening to to hear from Hawaii, they were in 1920 in the same situation that we in the State of Washington are now.

Today, I would like to talk a little bit about our basic health program, which I think is the innovative program we introduced.

I would also like to talk about broader issues. I think the issue of the uninsured is a much broader issue. It is not simply the matter of a basic plan here, or whatever, but it actually has to do with the restructuring or reform of our health care system.

Let me begin with the basic health plan. To be very brief, it is similar to the SHIP program, probably by no accident. It was a program first proposed and conceived by now-Congressman Jim McDermott when he was in our State senate.

It is a State-subsidized sliding scale insurance program. It is a program where individuals buy in, and we, through the State contract as a group with providers.

It has worked very well so far. We are basically tooling up now, but we have 10,000 enrollees, and we will go to 25,000. It is only a pilot program, but I think it is certainly a way to bring a lot of people who are uninsured into mainstream care.

Of interest, when we first proposed that, we did have a proposal for a pay or play tax that didn't survive. Of interest, if you have something like that, you can get very close to universal coverage in a State such as Hawaii.

Of interest, also, in our experience, as far as voluntary programs go, first from our research and also from our experience so far, is that it appears only about 50 percent of the eligible uninsured actually enroll in a program such as this, which means you still have a problem of 60 percent of the others. That is where some other program, something having to do with employers, are necessary.

We have done much more than the basic health plan. We have expanded Medicaid, provided programs for children under poverty

who are covered by a State-funded program. We have a high-risk pool. We have a number of other programs.

And over the last 4 years, despite putting all these things in place, we have actually more uninsured in our State than we had before. We feel a little frustrated by that. The primary reason is that, we have had an erosion of our employer-based insurance.

Dependents are not being covered. That is the issue everywhere. As we start stepping up to the table as a State, we see our health costs going from 10 percent 10 years ago, to 14 percent of revenue this year. We will be at 23, 24 percent in 10 years. That is with no policy changes.

If we try to cover the uninsured during that process, we will be spending over 30 percent of our State revenue. It is difficult to raise taxes or cut education programs. These are hard tradeoffs for our Governor and politicians to make.

This is not only the State government. It is also our employers. As you know, our employers are faced with 20-percent increase in rates. As we look at the problem, we see one that is broader, and we also see we have to include more than just a public sector in the response.

The points that I really want to make today are that we have to look beyond the public sector. We also need to focus broader than access. We are not going to be successful by concentrating only on access in the long run.

We have to look at access cost, appropriateness of services, a whole package if we are going to be successful. And the issues in our health care system are the lost opportunities. We lose a lot of things in the State government and we are going to lose a lot more in the future if we don't do something to control costs.

We look at the solution as being multi-faceted. We see the private and public sector working together. We see the Federal Government working with the States. I think there is no doubt on the access side, for instance, like in Massachusetts or Hawaii, that States can do a lot of it on their own.

That doesn't give them the control over the health care system. I think if you look at their health care inflation and the percentage of their tax burden, in fact health care is motoring along in those States as well, or possibly faster than they are in other States.

Also, the issue of equity amongst people throughout the country will have to be addressed. I think to have only certain States with solutions and other States without, begs the issue. We need to look at the differentials from State to State, region to region.

The main point I want to make today, as we move ahead in this whole process, is what we need to better organize our health care system. Right now, as we are trying to organize internally in our State.

We find decisionmaking is almost impossible. We find decisions for health care decisions are being made in Baltimore, Hartford, by self-insured, a lot of them out of State. That includes ERISA protections. We have some decisions being made in the State capitol, but basically, it is very difficult to find a nexus, one place, where we can actually put our fingers on where the system is being controlled. In fact, there is no place.

The problem we find that everybody is applying patches in all sorts of different directions. In fact, as we put any new Medicare or Medicaid trends on, there are other trends rolling along at their own speed and out of control.

Right now, from the State perspective, we have public health, health education long-term care, and we have a fairly large part of acute care. But we don't have the main running engine, which is the rest of acute care.

If one looks at solutions that supply Medicare or Medicaid to the uninsured, we see ourselves being put in a situation where we have more difficulty controlling what is going on. Our thoughts are we have to work with the Federal Government, give States the options to do a number of things, but to do that, we have to include the Federal programs and private programs into those solutions to be successful.

In the meantime, until the Federal Government does act, as you know you aren't rushing quickly, we think it is important to be flexible. I second the statements of the gentleman here from the State of Hawaii—which I enjoy visiting now and then—that there are ways for the programs—Federal programs, private programs, to be integrated with the State into another care system.

I want to thank you for the opportunity to speak, and I'll be happy to answer any questions.

Chairman STARK. Thank you.

[The statement of Dr. Crittenden follows:]

Statement of:

Robert Crittenden, M.D., M.P.H.
before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C.
June 12, 1990

Mr. Chairman and members of the committee, it is a pleasure and an honor to be here today. I am Bob Crittenden, Special Assistant for Health to Governor Booth Gardner of the state of Washington.

The issues being discussed here today have been the subject of considerable effort by the leaders in our state. Governor Gardner has overseen and promoted various landmark pieces of legislation. The Basic Health Plan, initially conceived and promoted by now Congressman Jim McDermott during his tenure in our State Senate, is an example of our progressive approaches to the health care conundrum.

The Basic Health Plan is a state subsidized sliding scale health insurance plan that enrolls low income individuals and contracts for their care on a group basis. It is currently tooling up and has 10,000 enrollees. It is a pilot with a maximum enrollment of 25,000 - a small part of our uninsured problem. It is an example of creative thought and action. Low income and poor people in the state can now buy in to mainstream health care.

But our efforts reach far beyond that. We have also:

- Expanded Medicaid to its maximum,
- Developed a state funded program so that all poor children will have coverage,
- Improved reimbursement rates for providers of care for children and pregnant women.
- Initiated a high risk pool, and
- Addressed many rural health care issues.

Yet, we are worse off now than before we began our aggressive attack on the uninsured. There are more uninsured, more people with limited access, and more people at risk of financial disaster. Our patches have not been broad enough. We have been short sighted in our work. We have been trying to solve access as an isolated problem.

As you are all well aware, the problem is broader than merely purchasing health insurance for the current uninsured. The decline of employer based insurance especially as it relates to dependents, the financial damage done to families if they happen to fall between the cracks (and we all have a story of someone who has fallen through), the rapidly escalating costs of health care services and the lack of appropriate incentives to providers, as well as consumers, highlight the fact that the health care system in Washington State and throughout the country is out of control.

We in state governments do not control the system. You at the federal level do not control this health care system. Employers do not control the system.

Let me use the cost side of the problem as an example.

We are all practicing expenditure control; that is, trying to control the amount we spend on health care while enabling the system to spin out of control.

This is why our state is facing annual 14% increases in health care costs. We now spend 14% of our revenue on health. By the year 2000 we will be spending 24% with no change in policy or increase in coverage for the uninsured. We will spend 30% or more if we cover the current uninsured.

This is why small businesses and individuals are facing 20 percent annual increases in health care costs.

In Washington State we responded in a number of ways.

We created a Health Care Authority to improve our purchasing of health care. The state has moved to self-insurance on the indemnity side of its purchases and we are now examining the full range of health care purchasing done by our state. Outside of Medicare, we are the largest purchaser of health care in our state. We hope to make our purchases more effective and efficient. Also, we are developing positive working relationships with the private sector concerning issues of common interest.

We also created a new department of health that is empowered, among other things, to work with the private sector to develop practice guidelines to improve the appropriateness of the services provided.

And, we just initiated a commission process that involves the private sector in addressing cost control, providing access to all of our citizens and improving the medical malpractice problems.

As we progress, there are a number of things that are evident.

- The public sector will not be able to solve these problems alone. The private sector will need to be active partners. For example, costs are controllable if individuals and purchasers are part of the solution. Less administration and cost shifting, consistent utilization management, and more efficient capital investment are examples of areas where individuals, all purchasers, public and private and most providers have a strong interest.

- Our focus needs to be broader than access. While we need to ensure all people access to care, simply buying more people into the current health care system will not be affordable or acceptable to those people paying the bill. Costs need to be controlled. And, appropriateness needs to be ensured.

- We face the lost opportunities that come from increased health care inflation. Education and economic development, among others, will continue to suffer as we invest more of available revenue on health care.

- A successful solution will take the cooperation of the federal government, the states and the private sector. While we need a federal solution the health care problem so there is consistency and equity among differing areas of the country, we also need to give states some control over how we organize and manage our own health care systems. And, the states need to provide a local focus for consumers, payers and providers.

- My main point is that we need to better organize our health care system, not worsen its present disjointed nature. Now, because health care in Washington State is administered in so many places -- Baltimore, Hartford, Olympia, Seattle, and many other places -- it is difficult to provide any consistent incentives. Proposals that put the patches on the uninsured problem at the federal level through Medicaid or Medicare may buy more of the uninsured into the current system, but they make the task of organizing the health care system more difficult.

  We now have health education, prevention and public health, much of acute care and all long term care managed at the state level. All of these suffer when overall acute care system is running without control. And, as the nexus of most of the health care system is at the state and local level, pulling parts out and putting control of them at the federal level makes our tasks more difficult.

  If the public and private sectors want to affect the current health care system, we need the tools. We need them in a usable form and we need them in one place. The states, in conjunction with employers, employees and other individuals are the logical level to best manage this system within a federal solution that covers the equity issues of eligibility, benefits and financing.

  Until the federal government acts, a reasonable federal response would be to allow flexibility on the part of the Medicare and Medicaid systems so they may integrate with state reform attempts.

In summary, I believe that we must think more broadly than we are used to. We need to get beyond isolated patches dependent on jurisdiction. We in Washington are feeling the pain of the health care system even with our extensive set of patches. We are trying to develop a more comprehensive system. Your help would be appreciated.

Thank you for this opportunity to share my thoughts and concerns.

Chairman STARK. Dr. Beauchamp. Did I pronounce that right?

STATEMENT OF DAN E. BEAUCHAMP, PH.D., DEPUTY COMMISSIONER, DIVISION OF PLANNING, POLICY AND RESOURCE DEVELOPMENT, NEW YORK STATE DEPARTMENT OF HEALTH

Mr. BEAUCHAMP. Yes, sir. Thank you, Mr. Stark.

I am very happy to be here today to discuss the proposal of the New York State Department of Health for Universal New York Health Care—UNY Care. It is very clear to us that, if we are to achieve true access to affordable care for all, we cannot continue business as usual. Too many of our residents have either too little or no health insurance.

Equally alarming, those who do have insurance are paying more and more for less and less. Our systems of public and private insurance are breaking up. Runaway medical inflation is the chief culprit. The problems of the uninsured and that of medical inflation are joined at the spine in our health care system. A program to make health care available to all most also incorporate strong cost control mechanisms.

How do we propose to solve this problem? Under UNY Care, we would assure individuals access the same way as Massachusetts and Hawaii are attempting, building on the employer-based system of coverage. We go one step further, however, in proposing that the health care insurance system be reformed so that an increasing of our health care dollar is devoted to providing health care rather than paying for administrative overhead, loans from banks to cover delayed payments, and other inefficiencies.

The major new idea behind UNY Care is to gain strategic advantage over the biggest source of red tape and waste in our health care system, the paperwork and delays associated with the myriad public and private payers, while at the same time better controlling, and speeding up, the flow of revenues to hospitals, nursing homes, and physicians.

We achieve this strategic advantage in three, easy-to-understand steps:

One, health insurance under UNY Care would be simplified and made more uniform. Everyone would be free to choose from three or four basic coverage packages, each offering a standard package of benefits.

Individuals and groups could obtain additional coverage beyond our benefits, although we hope that our plan's coverage would be generous enough to minimize this. Insurance would shift to community rating principles; practices like medical underwriting and preexisting conditions clauses would be phased out.

Two, all insurance companies would be required to use a new, statewide electronics claims system. Paper claims would be rapidly phased out. In addition to existing insurance cards, each New York State resident would be given a UNY Care card to access the system.

Three, providers will bill the single payer system, not insurance companies. Patients will no longer file claims. The single payer system will pay providers. Eligibility determinations would be made by the single payer system, which operates like an electronic

clearinghouse, based on a statewide file. Insurers will, in turn, reimburse the single payer system. Advance payment based on expected levels of revenues would be routine rather than the exception. Claims auditing would occur separately.

This simple system would eliminate vast amounts of paperwork and confusion for providers and consumers alike. Coordination of benefits among differing carriers would be vastly simplified.

The technology for implementing such a system is at hand. For example, the EDS Corp. has implemented a nationwide claims system for the General Motors Corp. based on eliminating duplicative and wasteful separate claims systems operated by over 100 plans serving 150 plants, each with local plant variations.

General Motors cut its growth in the costs of providing health care benefits by half using this approach. It is only the first step envisioned by UNY Care.

Obviously, the existing system of cost restraint for hospitals and nursing homes would remain in place. We are also proposing extending this system to physicians, somewhat along the lines of the scheduled resource-based fee schedule adopted last year for Medicare. Creating a single payer system adds the significant advantage of removing obstacles to a stable, rapid revenue stream for all providers, essential if additional cost restraints are put in place.

To address these gaps in coverage, we have developed a two-pronged expansion of insurance. Individuals who are employed or are a dependent of an employed individual would receive coverage through expanded job-based insurance.

People without jobs and those who are self-employed would have access to reasonably priced private insurance policies which would provide very comprehensive standard benefit packages. Subsidies would be made available to help individuals and families whose income is below 200 percent of poverty. Businesses, particularly small firms, that begin to provide health insurance for their employees under this program would also receive financial assistance.

I think I will stop there.

Chairman STARK. Without objection, your statement will appear in the record.

[The statement and attachments of Mr. Beauchamp follow:]

Statement of Dan E. Beauchamp, Ph.D.
Deputy Commissioner
Division of Planning, Policy and Resource Development
New York State Department of Health

Testimony Presented to the
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives

On Universal Health Care

June 12, 1990

I am very happy to be here today to discuss the proposal of the New York State Department of Health for Universal New York Health Care - UNY*Care. It is very clear to us that, if we are to achieve true access to affordable care for all, we cannot continue business as usual. Too many of our residents have either too little or no health insurance. Equally alarming, those who do have insurance are paying more and more for less and less. Our systems of public and private insurance are breaking up. Runaway medical inflation is the chief culprit. The problems of the uninsured and that of medical inflation are joined at the spine in our health care system. A program to make health care available to all must also incorporate strong cost control mechanisms.

During our talks around the state we continuously stress that medical inflation is threatening everyone's insurance, and that, conversely, we can't beat medical inflation unless everyone is insured. How do we propose to solve this problem? Under UNY*Care we would assure individuals access the same way as Massachusetts and Hawaii are attempting, building on the employer-based system of coverage. We go one step further, however, in proposing that the health care insurance system be reformed so that an increasing proportion of our health care dollar is devoted to providing health care rather than paying for administrative overhead, loans from banks to cover delayed payments, and other inefficiencies.

The major new idea behind UNY*Care is to gain strategic advantage over the biggest source of red tape and waste in our health care system -- the paperwork and delays associated with the myriad public and private payers -- while at the same time better controlling, and speeding up, the flow of revenues to hospitals, nursing homes, and physicians.

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2. All insurance companies would be required to use a new, statewide electronics claims system. Paper claims would be rapidly phased out. In

addition to existing insurance cards, each New York State resident would be given a UNY*Care card to access the system.

3. Providers will bill the single payer system, not insurance companies. Patients will no longer file claims. The single payer system will pay providers. Eligibility determinations would be made by the single payer system based on a statewide file. Insurers will, in turn, reimburse the single payer system. Advance payment based on expected levels of revenues would be routine rather than the exception. Claims auditing would occur separately.

This simple system would eliminate vast amounts of paperwork and confusion for providers and consumers alike. Coordination of benefits among differing carriers would be vastly simplified.

The technology for implementing such a system is at hand. For example, the EDS corporation has implemented a nationwide claims system for the General Motors Corporation based on eliminating duplicative and wasteful separate claims systems operated by over 100 plans serving 150 plants, each with local plant variations. The General Motors national claims system serves over two million members without any paper whatsoever. This same system of eliminating the waste and duplication is being extended to many other major corporations.

While achieving simple, easy-to-understand insurance policies, and eliminating administrative waste is an important goal -- General Motors cut its growth in the costs of providing health care benefits by half using this approach -- it is only the first step envisioned by UNY*Care.

Creating a single payer also will enable the separation of the flow of revenues from the individual claims. Advance payment will be a matter of policy, not discretion. Revenue flowing to hospitals and physicians should be accelerated and made more reliable. Costly borrowing by hospitals should be reduced, another source of savings.

Obviously, the existing system of cost restraint for hospitals and nursing homes would remain in place. We are also proposing extending this system to physicians, somewhat along the lines of the scheduled resource-based fee schedule adopted last year for Medicare. Creating a single payer system adds the significant advantage of removing obstacles to a stable, rapid revenue stream for all providers, essential if additional cost restraints are put in place.

States must accept the responsibility to devise reasonable, acceptable means for controlling the growth of costs. We believe reforming insurance, and the supporting billing and payment system is central to any successful cost control strategy. Nevertheless, we must proceed cautiously in stepping up cost restraint at the state level. Predicting state revenues is always a difficult task; it is even more difficult in the current fiscal climate. Cost restraint must take into account the difficulties associated with maintaining adequate state and federal revenues, and must somehow build in capacity for a public authority under UNY*Care to assure reasonably stable, reliable funding for all providers over time.

I have noted that we would expand insurance. Approximately 2 million New Yorkers or 11 percent of the state population are without any health insurance at all and many more are underinsured. Roughly two-thirds of the uninsured have some connection to the workforce. The greatest tragedy is that the largest group of the uninsured in New York are children under seventeen years of age.

To address these gaps in coverage we have developed a two-pronged expansion of insurance. Individuals who are employed or are a dependent of an employed individual would receive coverage through expanded job-based insurance. People without jobs and those who are self employed would have access to reasonably priced private insurance polices which would provide very comprehensive standard benefit packages. Subsidies would be made available to help individuals and families whose income is below 200 percent of poverty. Businesses, particularly small firms, that begin to provide health insurance for their employees under this program, would also receive financial assistance.

In order to comply with current ERISA prohibitions we have proposed a system, similar to that developed in Massachusetts, under which employers would be assessed a payroll tax equivalent to 12 to 13 percent of the first $14,000 of wages per employee. Employers that provide adequate health coverage for their employees would be eligible for a tax credit against this expenditure. Employers offering coverage for the first time would be eligible for subsidies to assist them with premium costs. We realize fully that we must carefully work with employers to address their cost concerns and intend to do so. Equally important is the need to

educate both employers and the public on how much the current system is already costing them and just how inequitable it is. In particular the small business person needs to know that any universal system proposed is built around basic reforms in health insurance, reforms which are critical to meet the needs of smaller firms.

It is obvious that simply providing coverage may not be enough if an individual cannot afford deductibles, co-payments and other health care costs. To address this we propose that low income individuals, those with income below 200 percent of the federal poverty level, be assisted with their health care costs through a system of income-based subsidies. These subsidies would be structured so that an individual whose income is equal to the federal poverty level would pay nothing while an individual with income equal to 200 percent of the federal poverty level would pay a maximum of $1,000 a year for health care. The universal enrollment file I mentioned earlier would be essential in monitoring these subsidies.

Finally, controlling costs means more than just setting rates for providers, it means budgeting health care. The UNY*Care system offers a powerful tool for allocating revenues to areas of greatest need. With a statewide budget we would be able to, at least at the margin, allocate resources within the system such that priority needs are met and the system is run in the most efficient manner possible. A statewide health budget, including annual projections of cost increases and anticipated revenues, would help us to better plan for future system growth and make recommendations for necessary adjustments in taxes, premiums and reimbursement levels.

Universal New York Health Care

A Proposal: Revision I

New York State Department of Health

May 10, 1990

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

DAVID AXELROD, M.D.
COMMISSIONER

May 10, 1990

Dear Colleague:

I invite you to read the first revision of the UNY*Care proposal since it was initially released on September 1, 1989. The changes in this version reflect many of the comments of our UNY*Care Advisory Group, which Governor Cuomo directed us to establish. This group, comprised of national and state experts on the issue of universal health insurance coverage, met three times in late 1989. Their review of and deliberations on the proposal are summarized in the back of this document.

Governor Cuomo has directed us to meet also with interested parties and individuals across the state to obtain their suggestions on how to improve UNY*Care. For the past several months, we have met with hundreds of people who have expressed deep concern for the uninsured, the underinsured, and excessive medical care inflation. Many of their comments parallel those of the Advisory Group, and are also incorporated into this version.

The major revisions included in this version pertain to the following: 1) clarification of the Single Payer's two roles; 2) clarification of employers' responsibilities for purchasing health care coverage for full-time and part-time workers; 3) the form of governance for UNY*Care; 4) the impact of UNY*Care on HMO's; and, 5) the excessive costs of our health care system and the limited success of our multiple payer system in controlling costs.

Governor Cuomo has begun to phase-in certain aspects of the UNY*Care proposal as it relates to coverage for uninsured children and streamlining the cumbersome billing and payment system. We are continuing to meet with interested groups to elicit their suggestions on how to refine and strengthen the proposal. We intend to issue a second revision in late summer or early fall.

For this purpose, we would appreciate having your observations and suggestions regarding this first revision.

Sincerely,

David Axelrod, M.D.
Commissioner of Health

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EXECUTIVE SUMMARY

While New York State remains a leader in health policy, our system has not escaped the gaps in insurance coverage, excessive costs, and other shortcomings that plague health care in the United States generally. Despite our evident achievements, the current system of multiple private and public payers cannot meet the more difficult and complex needs that have evolved in the decades since Medicare and Medicaid were enacted. Gaps in coverage constantly reappear, competitive pressures force insurers to avoid the truly sick, and new challenges like AIDS threaten to overwhelm the system. Without some fundamental new approach the state is not likely to ever eliminate the chronic, recurring inability of the public and private systems to offer comprehensive medical care to the entire population.

This report documents the chronically shifting insurance coverage for millions of New York State residents. While there are approximately 2.5 million New Yorkers without any coverage, millions more have limited coverage for certain types of care. For example, nine out of 10 New Yorkers have minimal long-term care coverage. Primary care insurance for low income women and children is severely lacking. New York's Medicaid funding has risen and fallen over the past decade. The number of uninsured New York workers increased 41 percent between 1980 and 1986.

This report also states the obvious -- medical inflation is excessive and our current methods for controlling cost are not sufficiently comprehensive. Nationally, annual medical care inflation historically has been twice that of the Consumer Price Index, and inflation's price tag of about $4.5 billion this year for New York State alone does nothing to address the problems of the inadequately insured. An increasing amount of our economic output is being consumed by health care. In 1970, 7.4 percent of our economy was devoted to health care. In 1980, the percent was 9.1 percent, and in 1990, the amount is projected to be 12 percent, a one-third increase over 10 years. Canada expends only about 8.5 percent of its GNP on health care, about a third less than us, yet all Canadians are insured and their health status is somewhat better.

The way we pay for health care contributes to medical inflation and recurring gaps in coverage. Our multi-payer system limits our ability to control costs and to manage health care resources. As costs rise, coverage shrinks. Universal access and cost control must be joined in a single framework if success is to be won.

This report outlines a system of stable and affordable health care for all New Yorkers -- Universal New York Health Care -- UNY*Care, combining cost control and expanded tax-based programs and private insurance. While a completely tax-based system might be the most effective and equitable approach to achieving these goals, our proposal concludes that such an approach is not initially feasible. On the other hand, we have rejected using only an employment-based approach as in Massachusetts, because it alone does not reform the payment and enrollment systems. Without linking the two key steps of expanding coverage and controlling costs, affordable universal coverage will likely remain an illusive goal. Therefore, UNY*Care rests on two basic principles: 1) universal coverage can only practically be afforded by accepting and strengthening the system of private, employer-based insurance and by expanding public programs for those not in the work force, and 2) this incremental improvement must be linked to a fundamental reform of the payment system with all providers facing a single payer, and with all residents being assured access to a sufficient level of care.

The UNY*Care Proposal outlines the basic building blocks of such a system, using a combination of employer-based and public-sponsored coverage. UNY*Care would extend preventive care to all residents from birth to 17, regardless of income and would strengthen primary care programs for all low-income people. Catastrophic benefits would be extended to all New Yorkers. The 15 percent of the population who have no coverage at all will be protected, either through tax-supported or employer-based coverage. More specifically, UNY*Care will provide for the following:

- A single-payer authority will be deployed between third-party payers and providers. (See Figure 1). Reforming the billing and payment system will be the first phase-in of the single payer authority. Our illustration depicts the payer authority's central role in assuring prompt payments to providers. Providers will be guaranteed payment for covered services and will no longer face multiple billing procedures, requirements and incentives. The payer authority (or its agent) will bill appropriate third party payers for each patient; providers will interact with one payer thus reducing administrative and billing costs and avoiding burdensome coordination of benefits issues. Shifting to a responsive, less inflation-prone system will require a major overhaul of our billing and payment system. A regional demonstration project will be carried out to prove the feasibility of creating an integrated electronic claims processing system that operates much more efficiently than our current one, achieving the rapid payment and other economies of a single payer system.

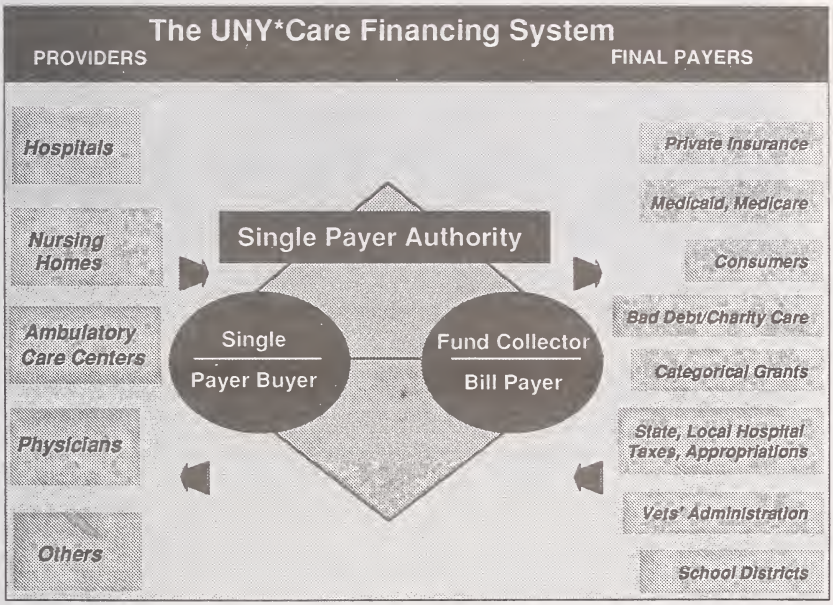

Figure 1

- All New York residents will be issued a single enrollment card establishing membership in the UNY*Care system. Figure 2 describes this fundamental change in the enrollment system with each resident treated alike in terms of service delivery and billing.

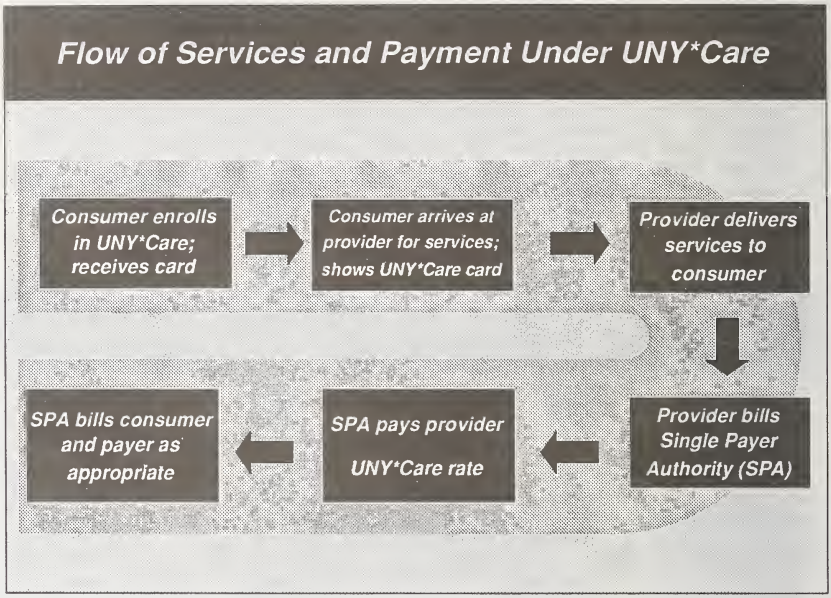

Figure 2

- Beyond overseeing the creation of an integrated billing and payment system, the single payer authority will also act as a rate-setter and negotiator, determining uniform rates of reimbursement for all providers. Through this authority state government will be permitted to act as a purchaser and buyer of medical care rather than one of many agents who pay for it, a crucial system change if costs are to be brought under control and coverage made universal.

- UNY*Care will provide public coverage for all persons with income at or below 100 percent of the federal poverty level, will subsidize coverage for all persons with income between 100 and 200 percent of the federal poverty level and will provide access to preventive care for all children 0 through 17 years of age, regardless of income.

- UNY*Care permits the development of a health care "budget" detailing all projected cost increases on an annual basis, and expected revenues from all sources of payment. Such a budget will permit elected officials, affected groups, the public, and UNY*Care administrators to plan for needed system growth, including increases in reimbursement, premiums, and new state revenues.

- The responsibility of private insurance to cover health care costs will be limited to a basic annual amount, roughly $25,000 each for inpatient and major medical care. The state will cover catastrophic medical expenses beyond the $25,000 minimum. (See Figure 5, page 11, for a summary of the provisions and operation of the package of benefits).

- Recommendations for phasing-in the program gradually are presented below. The proposals range from the Zero Option, which restructures the Bad Debt and Charity Care Pool to major new access initiatives that cost approximately $700 million in new state revenues. Any option adopted should contain the single payer structure, an essential element of UNY*Care.

- In financing expanded coverage, a fact often ignored is that new costs to society can be limited by restructuring the use of certain resources already available. UNY*Care proposes to convert to insurance coverage the present expenditure of $1.1 billion in bad debt and charity care funds (comprised of payer contributions and local taxes), and also to capture a portion of the nearly $4.5 billion annual increase in medical care inflation currently paid to providers to help fund the costs of universal coverage. UNY*Care will also ensure that care is delivered more efficiently and that the responsibility for paying for health care is equitably shared. Employers who do not pay for coverage now would start doing so and receive a subsidy to help them. People who can pay something but do not, will start. State government will pay for those who cannot, and will raise the money equitably through tax levies.

  The overall net financial impact on society for expanding coverage will also be limited because the people of New York State already are paying, in large part, for the sick care of the inadequately insured. Their lack of insurance does not keep them from becoming ill and seeking services. But, the way their care is financed is inequitable and the way their care is delivered is inefficient, problems that UNY*Care will address.

Table 1

	New Public Revenues Beyond $1.1 Billion Bad Debt and Charity Care
I. **Zero Option**:	$0 -- $100 million
Includes: Insurance for all uninsured persons not in labor force, mandated insurance for employed uninsured, single payer structure, small business subsidy. Stop Loss*. Source of funding: $1.1 billion bad debt and charity care pools, plus up to $100 million in general revenues.	
II. **More Access and Limited Economic Incentives**:	$250 million
Includes: **Zero Option** plus limited business subsidy including single payer structure, plus public funding of primary and preventive care program for all women, children, youth to age 17. Stop Loss*. Source of funding: $1.1 billion bad debt and charity care pools plus $250 million in additional general revenues.	
III. **Full Access and Economic Incentives Option**:	$700 million
All programs under Options 1, 2, single payer structure, plus major subsidies for all business offering insurance for first time. Stop Loss*. Source of funding: $1.1 billion bad debt and charity care pools, plus $700 million general revenues.	

*Because the stop-loss program is self-financing, it is not entered as requiring new revenues

UNIVERSAL NEW YORK HEALTH CARE (UNY*Care)

The health care system for New York State faces serious and widely acknowledged challenges. The magnitude of public and private resources New Yorkers devote to health care is surpassed by few nations in the world. As the nation's second largest state with its largest city, our health care problems range from recruiting physicians and other personnel for sparsely-populated rural areas and crowded ghettos, to managing the health care systems of a vast metropolitan region containing some of the finest medical centers in the world. New Yorkers spend over $40 billion on health care each year, and are increasing that amount annually by about $4.5 billion; despite our myriad cost control attempts, medical care inflation continues to be double that of the Consumer Price Index and health care costs relentlessly consume a growing proportion of our Gross State Product. Against this backdrop of excessive inflation, public and private managers struggle to find resources to stem the AIDS epidemic, overcome personnel shortages, and to treat the uninsured.

The policy challenge of today's health care system is vastly different from twenty years ago when Medicare and Medicaid were passed for the nation's elderly and the poor. These programs expanded access for millions, and private insurance coverage also continued to expand. Yet this period of growth seems to have reached its limit during the early eighties. We now face a new policy reality. Despite its successes, our current system of private and public programs cannot match the job. Chronic gaps in coverage constantly re-appear, competitive pressures force insurers to avoid the truly sick, and new challenges like AIDS tend to overwhelm the system.

The New York Academy of Medicine, in its August 1988 report advocating universal coverage, sums up the central failures of our present system:

> "In the decade following the Second World War, there was dramatic improvement toward a health care financing system that would cover all Americans. Over the last decade this trend has begun to reverse... The private employment-based insurance structure is fragmented. Medicare...fails to meet the current needs resulting from demographic and technological changes. Medicaid funds intended to protect the poor, have increasingly or disproportionately been diverted to plug the gaps in the federally funded Medicare program.... The private employment-based structure has contributed to an erosion of the essential social risk pool through experience-rated selectivity of coverage. At the same time it has failed to respond to changes in labor market patterns, leaving many members of the increasing part-time work force without any health insurance coverage."

The recurring gaps in coverage are the most visible signs of the system's distress. Gail Wilensky, senior health economist with Project Hope, notes that the number of uninsured tends to rise and fall with the vagaries of political commitment, the business cycle, the structure of available jobs, and so forth. After decades of steady expansion, employment-based insurance has been falling. As Wilensky notes, the "most clear cut decline in coverage has been among workers and their dependents" (Health Affairs , Summer, 1988). Since 1980, 15 million U.S. workers or their dependents have lost job-based health insurance, and the number of uninsured New York workers has increased by 41 percent. Employers who maintain coverage for their workers pay

for health care twice -- once for their own employees and again as the costs of treating uninsured persons are factored into reimbursement rates.

Public programs have their own instability. By the mid-seventies, New York had the most generous Medicaid program in the nation, but with the fiscal crisis of New York City, Medicaid was sharply cut. We finally returned to the 1975 level of 100 percent of poverty for Medicaid eligibility with Medicaid legislation enacted during 1988. But there is no guarantee that new fiscal shocks may not undermine again the commitment to New York's poor (See Figure 3).

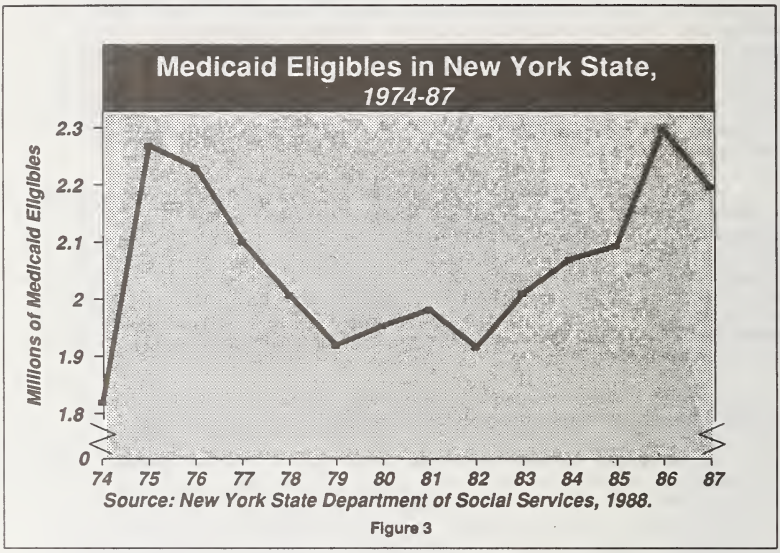

Figure 3

Gaps in coverage are not the only characteristic of a system strained beyond its capacities. Such a system has difficulty in effectively and equitably adapting to ever-changing health needs and service requirements because of its reliance on multiple, rigid reimbursement streams. Medicaid is increasingly being transformed into a long-term care program for middle class residents who spend down to gain nursing home coverage. Insurers increasingly seek to underwrite the healthiest, safest groups, leaving to government or the hospitals the care for those with the greatest need. Hospitals have become the treatment source of last resort, the last refuge for those who lack such elemental needs as housing, primary medical care, or drug or alcohol treatment.

Patients are only vaguely aware that behind their visits to doctors and hospitals stands a complex and unwieldy set of unrelated programs to control costs, assure equity, and promote quality. These separate programs have diffused responsibility for health care, in main because each program is an incremental response to a specific defect. Indeed, there is a connection between the recurring gaps

in coverage and the multiple streams for reimbursing health care, because this fragmentation disperses responsibility among different actors and institutions, leaving no one with responsibility for the needs of the state considered as a whole, as one community. This affects all New Yorkers. There is limited ability to make choices about what purposes our health care resources -- to which we all contribute -- should be put.

These problems have not evolved without warning. For half a century, advocates of universal health coverage at the national level (including many distinguished New Yorkers) have warned that a fragmented system would never be adequate to meet the needs of all citizens. We almost gained universal coverage during the mid-seventies. Then the issue vanished from the political scene.

After a decade of silence, universal access has returned to state and national agendas. Partly it is because, as the New York Academy of Medicine report suggests, there is a growing awareness of the permanent limits of our fragmented system of health care and its inability to assure access to health care for all people. Massachusetts has taken a step toward expanding coverage to all its uninsured. However, the Massachusetts program falls short of a universal system because it does not also make payment and enrollment universal.

New York doesn't need another set of programs to combat specific ills of our current system. What is needed is a universal health system that covers all residents regardless of their employment status and in a way that assures a flexible and rapid response to constantly changing needs and new health technology. At the present time New Yorkers have no adequate way to shape their health care needs as a whole community.

The Universal New York Health Care (UNY*Care) system offers a permanent closing of gaps in coverage for all New York residents, and reforms the present system of reimbursement, insurance, and payment in a way that assures that these gaps will remain closed and new needs met in a rapid, public, and equitable manner. It also assures that quality medical care and workable cost controls can be developed in a way that is equitable for all New Yorkers. Providing universal coverage and improving our health system involves more than plugging gaps. As the Subcommittee on Health Insurance of the New York State Council on Health Care Financing in its January 1988 report on the uninsured noted, "...the foundation of a comprehensive coverage strategy is a system which operationalizes a broad view of social responsibility to address the problem, balancing objectives and roles of all segments of the community."

Perhaps the basic reason New York is seeking to reform its health care system rests in the nature of our life together and our motives for political association. In the sphere of health, as perhaps in no other sphere of life, Americans recognize that we are all bound to one another: the problem of the insurance salesman in Syracuse whose aging mother must enter a nursing home is our problem; the problem of the young mother in Queens who works at a fast food chain that doesn't provide health insurance for its workers is our problem; the problems of children without basic preventive care is our problem; the problem of the addict with AIDS who cannot find treatment for his disease is our problem. All of these are our common problems. Yet without some common framework like UNY*Care we lack effective mechanisms to address these as common problems and to express and show our shared fate and our shared responsibility.

THE CHALLENGE: CLOSING GAPS IN COVERAGE WHILE CONTROLLING COSTS

There are roughly 2.5 million New Yorkers without any health insurance at all. Millions more are under-insured. The completely uninsured are evenly distributed between New York City and upstate. Indeed, the fastest rates of increase for the uninsured are in suburban and rural parts of the state according to a 1987 report by Signalhealth. In some parts of the state the highest percentages of uninsured are among children from 0 to 17. The uninsured do get health care, usually in hospitals, but research shows that the uninsured receive less hospital or physician care than the insured. The uninsured are less likely to have a regular source of primary health care, less likely to be hospitalized, and more likely to receive their care in emergency rooms. The ranks of the uninsured have swelled during the 1980s in the U.S., from 25 million to 37 million, primarily because of cuts in Medicaid and the shrinkage of private, employment-based insurance. Many of the uninsured in New York receive their care in hospitals with funds from the State Bad Debt and Charity Pools and from local tax revenues, but the evidence indicates that these pools are increasingly inadequate to meet the demands of the rising numbers of uninsured.

Primary and Acute Care

Primary care is the basic medical care provided when the patient first comes into contact with the health care system; primary care includes prevention, health maintenance, and general health care needs. Acute care is inpatient care, or outpatient care of an urgent nature.

Most New Yorkers do not have complete insurance coverage for primary and preventive care. This form of care is usually covered by out-of-pocket expenses except for the roughly 4 million residents who are covered by Medicaid or by a Health Maintenance Organization (HMO). Even HMO's are increasingly charging co-payments for routine office visits. Insurers and companies often control their costs by increasing deductibles. Thus, primary care is often the first casualty of cost control.

The most worrisome feature of this partial coverage for primary care is for low-income New Yorkers. For this group, out-of-pocket expenses serve as a barrier to necessary medical services like prenatal care or preventive services. Delayed or insufficient primary care only allows illness to progress and results in over-burdened hospital services. A principal goal of UNY*Care is to assure access to all primary and preventive services for persons up to 200 percent poverty as well as assuring preventive care for all children and youth, regardless of income.

About 15 percent of New York State residents -- 2.5 million individuals -- have no coverage for inpatient care. The largest group without coverage is aged 0-17; about 16 percent or 700,000 of these children are without coverage. About 11.3 million people or 63 percent of residents lack coverage for catastrophic inpatient care -- coverage for costly illness. Only about 6.3 million people have catastrophic coverage through Medicaid, Medicare, and HMO plans.

The age group that has the best inpatient coverage are those 65 and older. Only about 2 percent of the elderly have no inpatient coverage. Over 50 percent of the elderly have total or near total coverage for inpatient care, with minimal or no deductibles because their Medicare is supplemented by Medicaid, Veterans coverage,

or by HMO enrollment. Yet 40 percent do face deductibles of $540 for acute episodes and many are forced to purchase supplemental policies to cover this cost. UNY*Care will cover this deductible for individuals or families who fall below 200 percent of poverty.

Long-Term Care

Nine out of ten New Yorkers (15.6 million people) have either no long-term care coverage or minimal coverage. Ten percent (1.8 million) have total coverage because they are categorically eligible for Medicaid. Medicare provides almost no long-term care coverage. The basic orientation of Medicare is short-term illness.

Given this limit to Medicare it is not surprising that increasingly Medicaid is being used to finance long-term care, not only for poor New Yorkers but also for middle income residents who spend down to receive Medicaid coverage. This shift in Medicaid's structure seriously undermines its basic purpose of providing complete medical assistance for the state's poor.

The optimal solution to New Yorkers' long-term care needs would be changes in the national Medicare program to include long-term care in its basic provisions and re-orient its priorities to better serve the needs of its aging beneficiaries. This basic change would permit long-term care to be covered through the broad Medicare payroll tax base and would pose the smallest burden on individual beneficiaries, businesses, and taxpayers.

Failing that development, New York State must determine if it will develop a state long-term care insurance program or stimulate the private insurance market for future inclusion in UNY*Care.

Cost Control

The excessive increase in medical care costs are well documented. Health care costs as a percentage of our Gross National Product increased 32 percent in the last ten years. Employers see profit margins eroding and employees see a growing portion of their potential wage increases being diverted to pay for escalating health care costs.

Although many strategies have been used to contain health care costs, they have experienced limited success due to a basic structural flaw -- they are all operated within the context of a multiple payer mechanism. Controlling health care costs can be accomplished more effectively under a single payer system, which gives taxpayers and premium payers the necessary market power to arrange for reimbursement levels with providers that are less than double the inflation rate. Problems such as cost-shifting, providers shopping for those payers that offer the highest reimbursement, and payers attempting to outbid one another to enroll providers in their plans will disappear in a system where there is only one payer. Also, the structure for billing and payment can be greatly streamlined.

MEETING THE CHALLENGE: MAKING THE EXPANDED SYSTEM MORE UNIVERSAL

The two key components for UNY*Care's success are universal coverage and cost control, each a prerequisite for the other. Universal coverage involves expanding the system of coverage to include all middle and lower income New Yorkers. Cost control involves a single payer responsible for setting uniform reimbursement methodologies and rates and a single payer authority. Without a single stable source of payment, providers have strong incentives to shift the costs of uncompensated care to other payers. Without a strong system for restraining cost growth, sharply expanding coverage will help fuel inflation in medical care costs. Thus, UNY*Care expands coverage while restraining cost growth and reducing cost shifting.

The most distinctive feature of UNY*Care is the strategy of interposing a single payer between third party payers and providers. UNY*Care will set rates for all providers and act as the single payer for all hospitals, physicians, clinics and nursing homes. The single payer will function as a buyer of care rather than only a bill payer, implying a concern about appropriateness of care and quality. It allows for a direct relationship between providers and the state, shifting over time from formula-based reimbursement to negotiated rates consistent with state and private revenues. In its broadest sense buying health care means budgeting health care, moving closer to a total state health care plan that permits even, balanced growth in all areas.

A single rate for each covered service that is consistent across payers will remove the incentive to discriminate by type of coverage and enable providers to make decisions based on health conditions -- not reimbursement concerns.

UNY*Care (or its agent) will also operate as the single fiscal account for the multiple private and public payers of health care. Instead of the myriad public and private payers who now pay providers, and who operate with their own rules, criteria and levels of payment, only UNY*Care will interact with providers for billing and payment. UNY*Care, in return, will also interact with the payers. This important reform will result in significant savings in administrative and billing costs. Providers will be guaranteed payment for covered services, will no longer face multiple payers operating under different billing procedures and will only bill individual patients for non-covered services.

UNY*Care participants will each receive a standardized enrollment card establishing membership in the system. The card would be electronically coded with the patient's covered benefits, thus assuring the provider payment for the specified benefits.

Financing coverage for the inadequately insured can be accomplished largely by using differently certain resources that are currently available. The means for financing expanded coverage under UNY*Care will include restructuring the use of $1.1 billion in bad debt and charity care funds, investing a modest portion of the $4.5 billion annual inflationary increase, and assuring that care is delivered more efficiently.

The structure of governance for UNY*Care is not settled and discussion as to its most appropriate configuration will continue. The creation of a UNY*Care public authority is one option. Others argue for a private rate-setting commission. Others claim that since UNY*Care has such a major public responsibility, it is most appropriately governed by another state agency. What is significant is that most all agree that UNY*Care will require a new organization at the state level with new responsibilities and roles. The nature of this body -- whether a new state executive department, a public benefit corporation, or some other structure -- requires further study and deliberation.

Reimbursing Hospitals

As Figure 4 shows, under the current system providers face multiple payers: Medicare, Medicaid, Blue Cross, HMO's, Worker's Compensation, No-Fault, and commercial insurance companies. These different payers not only present providers with a heavy burden of paperwork, they also encourage discrimination against those with less than adequate coverage. Also, different categories of payers pay differential rates: Blue Cross pays less than commercial insurers because it provides open enrollment, community rates, conversion rights, and Medicare Supplemental Insurance Pools.

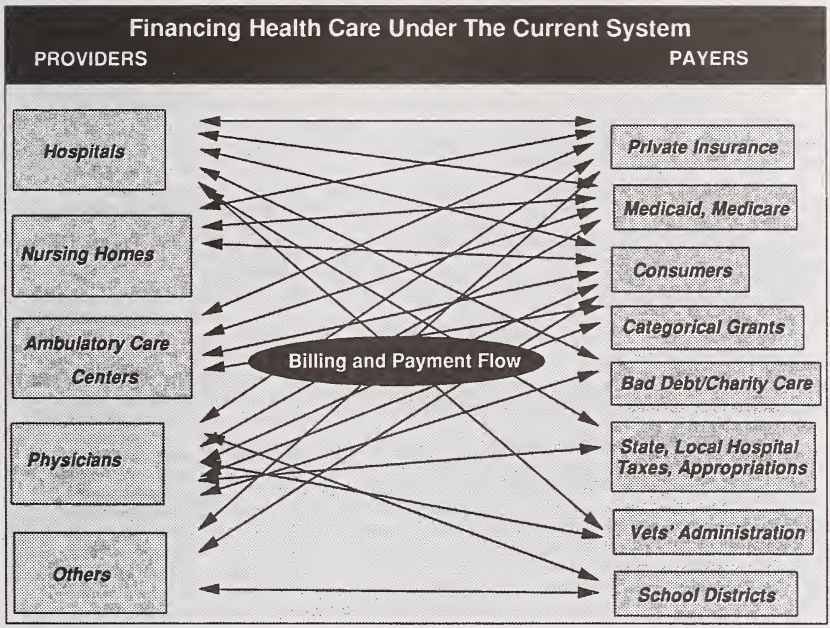

Figure 4

Moving to a one-payer system is a formidable challenge, but the groundwork has already been laid with the current all-payer system that has moved regulatory activity for hospitals in New York very close to a uniform reimbursement methodology.

Under the current system, all providers are reimbursed by a DRG, case-based, prospectively negotiated arrangement, but: 1) the Medicare rates are set by the Federal government and are generally higher than the non-Medicare rates, and 2) the Blue Cross differential persists (Blue Cross pays hospitals 13 percent less than commercial plans), although it is slightly lower than before.

However, NYPHRM as currently constituted, and in isolation, is insufficient to address the problems of gaps in coverage, cost controls, etc., identified previously. An evaluation of NYPHRM "I" by the Robert Wood Johnson Foundation suggested that regulatory coverage needs to include all payers and multiple settings, not just hospitals, in order to be successful in controlling cost. UNY*Care will, therefore, through the single payer authority, ultimately pay hospitals based upon a single all-payer DRG-based rate with some variations by region, hospital type, etc. Such rates will be phased in to account for the current differentials in commercial, Blue Cross, and Medicare payment levels. UNY*Care will provide incentives for non-Blue Cross payers to community rate, and the patient population characteristics that differentiate the Medicare from the non-Medicare groups (age, severity of illness) will be incorporated in the calculation of the single rate.

Reimbursing Ambulatory Care

"Ambulatory care" refers to providers such as clinics and diagnostic and treatment centers, rather than private physicians. The New York State Department of Health has recently developed and is now beginning to implement, on a demonstration basis, a system for the reimbursement of ambulatory care facilities using a classification system known as the "Products of Ambulatory Care," or PACS. Twenty-four per-visit patient product groups that recognize and categorize patient and service characteristics in ambulatory care have been identified and per-visit prices determined. This new methodology links the payment amount to patient characteristics and level of service, and thus will enable ambulatory care programs to be compensated in a manner that supports their appropriate role in the continuum of health care services.

Paying Physicians

Paying physicians is one area where the state has limited direct reimbursement responsibility, but the state's proven capacity in other rate setting arenas provides evidence that this challenge can be met.

There are several possible reimbursement methods that can be used. Simply paying what a physician charges provides no cost control and is rarely used. Paying billed charges so long as they do not exceed a specific physician's reasonable and customary charges or the prevailing charges of physicians in the community is the method currently used by many commercial insurers. This is still inflationary as providers are encouraged to increase their volume of services and "customary" cost behavior. Under a relative value scale physicians are reimbursed a predetermined amount based on the multiplication of a dollar value by a number designed to reflect the relative value of the service being reimbursed. The relative value scale can

be arrived at in various ways. It can reflect historical charges, that is, the market valuation of services, or actual resource costs. While many physicians are reimbursed in accordance with fee-for-service schedules, a growing number, between 40 and 50 percent, are salaried. Finally, under capitation, a primary care physician receives a set amount to cover the cost of office care he/she provides to a patient, or for services provided by specialists to whom he refers the patient. Thus, the physician is at financial risk for inefficiencies or excess. Capitation, however, encourages the greatest budgeting and prioritizing since income per patient is largely fixed and not associated with utilization.

Given the current preponderance of fee-for-service, and the difficulty of instituting a capitation system statewide, UNY*Care will seek to reimburse physicians on the basis of a negotiated fee schedule possibly based on a relative value scale while also seeking to encourage capitation wherever possible.

Reimbursing Long-Term Care

Residential long-term care facilities in New York State are paid in accordance with a case-mix reimbursement system known as "Resource Utilization Groups" (RUGs). This system, a prospective reimbursement methodology, employs case mix measures and allows facilities to be reimbursed based upon characteristics of their patients as measured by a patient classification system. The RUGs classification system is composed of 16 distinct patient groups, each of which differs in terms of clinical characteristics and resource utilization. The RUGs system categorizes patients into one of these 16 groups and reimburses facilities on the basis of the classification group.

Subsidizing Policies for the Uninsured

In addition to having the necessary reimbursement structure and authority essentially in place, UNY*Care will benefit from current state initiatives in order to make insurance universally available. The Expanded Health Care Coverage Act of 1988 authorized the implementation of a series of pilot projects to test alternative health coverage models. Nearly $13 million is available to support these pilot projects which are anticipated to assist approximately 14,500 individuals with the purchase of health insurance. Two different types of pilot projects will be developed, each targeted toward a different population. One pilot type will assist low-income individuals and families with the purchase of health insurance while the other will target the employed uninsured by subsidizing employer-based health insurance. The projects began enrolling beneficiaries during June 1989, and will continue until December 31, 1990. These efforts reflect a state commitment to the goal of universal access to health coverage and will provide important lessons and experiences for the implementation of UNY*Care, particularly regarding the subsidization of employer and individual contributions to premium costs. This aspect of UNY*Care, the expanding and financing of coverage, is described in the following section.

Expanding and Financing Coverage

The effect of a more uniform reimbursement system based on current methodologies, that uses one public payer, will help to build provider and public support for universal coverage. As argued above, this program, and the public support it engenders, is vital to the second side to universal coverage: financing the expansion of the present system to remedy the persistent, recurring gaps in health coverage.

Health care systems vary in their universal features by the way in which they are financed as well as the way in which bills are paid and rates are fixed. For example, in tax-based systems, when health care costs are financed through general taxes which have progressive features, aside from the ease of administration and simplicity of this approach, the citizen and the public official clearly understand that the risks for health are shared across the entire society, and not borne by the sick or particular age or occupational groups. The more a tax becomes regressive, the less this is the case; however, even in systems of social insurance like Social Security that are based on payroll taxes which employers and employees pay, the entire working population participates in financing pensions and hence participates in a common, universally-shared pool for security against loss of income in the non-working years.

For reasons we will briefly review at the end of this section, state-financed schemes of health insurance will have great difficulty in being totally or largely tax-supported systems. Nonetheless, these schemes can adopt other features of universal health insurance, like common enrollment as symbolized by a single membership card, uniform reimbursement, and the softening of the worst features of experience-rated insurance through catastrophic coverage provided by the state. They can also have a supplemental role in financing the components of the program outlined below.

What follows are the basic strategies for extending health care coverage to all New Yorkers. When combined with the UNY*Care single payer system which fixes responsibility on the state and employers for assuring coverage for all New Yorkers, a permanent and stable source of health care coverage for all should be within reach. The basic principles for financing and expanding this coverage are:

- A surcharge on the payroll of all employers is proposed to finance the costs of coverage for the working uninsured population. This approach assures that employers contribute to the health insurance costs of all their employees including part-time workers; however, employers can substitute payment of the tax for the purchase of insurance for part-time employees. All employers providing mandated levels of health insurance can avoid paying this surcharge. Employers newly offering insurance will be eligible for subsidies, which will be phased out over a four year period.

- Public programs to cover all persons under 100 percent of poverty will be continued. Coverage of those persons between 100 percent and 200 percent of poverty will be subsidized and all children under the age of 17, regardless of income, will be assured access to preventive care services.

- The responsibility of private insurance for health care costs will be limited to a basic annual limit, roughly $25,000 each for inpatient and major medical care. This basic annual limit, or stop/loss, will also be financed primarily through a surcharge on the health insurance premiums paid by employers, and through the use of other funds.

- The means for financing expanded coverage under UNY*Care will include restructuring the expenditure of $1.1 billion in bad debt and charity care funds, using a portion of the $4.5 billion annual increase in medical care inflation, assuring that the responsibility for paying for health care is equitably shared and that care is delivered more efficiently and appropriately.

The term "standard package of benefits" or "covered services" deserves elaboration at another time. For the present, the overall structure and fiscal implications of the basic package are sufficient. UNY*Care will specify a basic package of benefits which will serve as a standard for all benefit packages. This standard package of benefits will likely include routine physician visits, physical and occupational therapy, laboratory and diagnostic services, inpatient and catastrophic care. While this coverage will specify a minimum, the minimum will be sufficiently high to encourage acceptance by all parties as the basic standard of care. This package will not only define covered benefits, but will also limit total out-of-pocket expenses of individuals as well as the percentage of the premium costs borne by the employer and employee.

For all types of coverage, several common features emerge. Except for Medicare and Medicaid, all forms of insurance will carry coverage up to roughly $25,000 for both major medical and inpatient care during any given year. For costs beyond these amounts, UNY*Care will be the payer, using a surcharge on employers' health insurance premiums and other funds to finance this change. Also, for persons who fall below 200 percent of poverty, all or most out-of-pocket expenses will be borne by UNY*Care, again using Medicaid, where appropriate, or other state funds. The package described in the following pages is summarized in Figure 5.

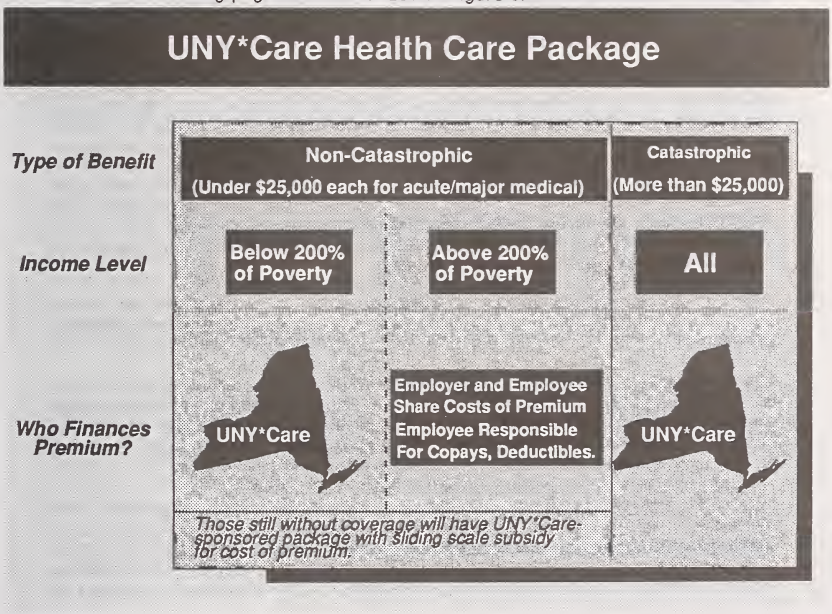

Figure 5

Primary Care

- **UNY*Care will assure that all infants, children, and adolescents, regardless of family income, have access to all necessary preventive health care by financing the cost and by expanding the use of schools as service sites.**

  Despite the importance of preventive health and health promotion measures, at present there is little financial coverage. Most insurance policies do not cover health prevention and promotion measures. The only two sources of coverage are Medicaid and HMOs, which cover about 1.5 million children and adolescents or only about one-third of all children.

  UNY*Care, under the Access Options, will fully finance the cost of preventive health measures for all 4.3 million children and adolescents according to the schedule for preventive health visits as recommended by the American Academy of Pediatrics. Approximately 8 million visits per year are required.

  For infants and children under five, a physician office visit and visits to clinics and OPDs will be reimbursed at $40 a visit. The cost for older children and adolescents will be less as the preventive and early detection services will be provided at schools for these nearly 3 million enrollees, where economies of scale allow for lower per unit cost.

- **UNY*Care will assure that all adults and children below 200 percent of the federal non-farm poverty level have financial access to all necessary primary care.**

  UNY*Care, under the Access Options, will assure access to preventive care visits for all adults below 200 percent of poverty. The total number of preventive visits this group needs is about 4.7 million annually. Another important component of primary care is the physician office or clinic visit to diagnose, treat, and manage health problems. This component is especially necessary for follow-up to problems identified in preventive care. UNY*Care will therefore also assure financial access to primary care visits by all people below 200 percent of poverty, both children and adults. The total number of anticipated visits, exclusive of preventive care visits, is about 17.0 million visits annually. Coverage will also include diagnostic and laboratory tests to ascertain the presence and nature of health problems, and ancillary services such as eyeglasses, hearing aids, dental work, and prescription drugs for those below 200 percent of poverty.

- **Other, more general barriers to primary care such as co-pays for low income persons, lack of provider interest in primary care, etc., will also be addressed by UNY*Care.**

  Low Medicaid Fee Schedule: Despite Medicaid's comprehensive benefit package which includes primary and preventive care, the low Medicaid physician fees preclude participation by significant numbers of private physicians. UNY*Care proposes to raise Medicaid physician fees and also takes steps to expand access for Medicaid eligible citizens.

  Lack of Physician Assignment: The lack of mandatory physician assignment in the Medicare program acts as a disincentive to Medicare eligibles' utilization of primary care services. Medicare Part "B" covers approximately 80 percent of the cost of office services, leaving 20 percent of the fee schedule, plus additional frequent charges by physicians over and above the fee schedule, to be paid by

recipients. UNY*Care reimbursement rates for all services will be deemed payment in full; physicians will not be permitted to bill separately. UNY*Care will, for a basic set of services, require mandatory assignment.

Insurance Deductibles Unrelated to Income: A typical large corporate plan provides 80 percent coverage after a $200 deductible, and 100 percent coverage after a $2,000 out-of-pocket cap has been reached. For many low income people, these shared costs can limit utilization. UNY*Care, under the Access Options assures financing of primary care visits for people with incomes below 200 percent of poverty, who represent almost one-third of the state's population.

Uneven and/or Limited Private Insurance Coverage of Primary Care: The primary care benefits of employer-based and individual insurance plans vary significantly. While some of this variety will remain, UNY*Care will be in a far better position to phase in a basic level of primary care and preventive services consistent with acceptable medical standards.

Inpatient, Major Medical, and Catastrophic Coverage

- **UNY*Care will function as a stop/loss source for all inpatient and major medical care insurance policies and self-insurance programs after a standard level of coverage has been exhausted.**

The state stop/loss for inpatient care and major medical expenses recognizes the fact that coverage for these expenses is limited. The only people who have total financial coverage for these events are those who are covered by Medicaid, and some HMOs. These three sources cover only about 37 percent of the State's population or about 6.3 million people. For the remaining 63 percent or 11.3 million people, the coverage varies from none to several hundred days of care or several hospital stays with a deductible and co-payment.

In order to assure catastrophic coverage for all persons enrolled in UNY*Care, a state stop/loss will be available to all employers, insurance companies, HMOs, self-insurance programs, and individual policies. No insurance plan will need to pay beyond a specified amount, for example, $25,000 of coverage each for inpatient care and major medical care. Policies which currently provide coverage beyond these specified amounts can restrict their coverage and their risk to those levels. The stop/loss provisions will not apply to Medicaid which already provides full coverage. Measures to ensure complete coordination of benefits will be implemented so that deductibles and co-payments will be covered by another spouse's policy if one is available.

The services covered beyond the stop/loss will be financed through the use of various funds. However, a large portion of the financing will be derived by assessing employers a surcharge on the health insurance premiums that they pay for the first $25,000 of inpatient care and the first $25,000 of major medical expenses. Employers that provide adequate catastrophic coverage will have the surcharge entirely, or largely, rebated. Conversely, those employers that provide inadequate catastrophic coverage will pay the entire surcharge.

The role of employers in financing health insurance coverage will become more equitable because of the stop/loss provision. This provision means that employers will carry the same high level of catastrophic coverage for each employee. The

stop/loss will reduce the need for experience-rated policies because catastrophic costs will be more evenly distributed across all groups. In addition, the stop/loss will help employers to project their policy costs more accurately since the unpredictability of catastrophic costs will no longer be factored into the policies.

- **All employers, regardless of size, will be encouraged to provide insurance coverage for their employees by applying a surcharge on their payroll. The coverage must be at least $25,000 each for inpatient and major medical care. A subsidy will be available over a four-year period for all employers that will be providing coverage for the first time under the Full Access Option.**

  Of the nearly 2.5 million people who are uninsured in New York State, about 1.2 million, or 48 percent of them, are employed or are dependents of an employed person. Thus, by offering incentives to employers to provide coverage, nearly half of the uninsured population will be covered for basic inpatient care and major medical care.

  All employers will be subject to a payroll surcharge, roughly equivalent to 12-13 percent of the first $14,000 of wages. Since the surcharge will be based on payroll, employers will be contributing at a rate that corresponds to employees' status as full-time or part-time workers. The state will provide its stop/loss protection after $25,000 each of inpatient and major medical care; thus, these 1.2 million people will be fully covered for these services.

  The employer can purchase a UNY*Care approved policy from any state-approved insurance company. UNY*Care will negotiate with insurance companies for the purchase of low-cost inpatient care and major medical care plans by many employers. By way of a massive purchase from an insurance company(ies), it is estimated that a $25,000 inpatient care and a $25,000 major medical policy could be made available for $2,700 and $1,200 for family and individual coverage, respectively. Such an approach minimizes experience-rated policies and adverse selection problems. Moreover, a massive purchase means lower administrative costs for each employer. The employer will be required to pay a specified portion of the premium, and the rest can be assessed, within limits, onto the employee by the employer. In addition, as an incentive to employers who are capable of doing so, and as support for those employers who cannot afford to do so, UNY*Care will also subsidize the premium contribution borne by employers who do not currently offer insurance. This subsidy will be phased out over a four year period.

  All employers will be subject to the payroll surcharge. Those employers that already purchase or choose to purchase coverage for their employees that meets UNY*Care's standards will be able to avoid paying all or most of the surcharge. For those who pay the surcharge, these monies will be used to finance the costs of coverage for the uninsured. Few employers will pay the surcharge since most of them already purchase coverage for their employees that would meet UNY*Care standards.

- **Comprehensive UNY*Care approved health insurance policies will be available to all self-employed individuals ($25,000 of inpatient care and $25,000 of major medical care). A sliding-scale subsidy will be available for those people below 200 percent of poverty. These policies will also benefit from the stop/loss provisions previously described.**

Of the 2.5 million people uninsured, about 265,000 are self-employed or a dependent thereof; of this number, about 162,000 are actually employed and 103,000 are dependents. This group comprises about 10 percent of the 2.5 million who are uninsured. UNY*Care will offer the self-employed the opportunity to purchase the same $25,000 inpatient care and major medical policies with the stop/loss benefit that will be offered to employers. Approximately 46 percent of self-employed people and their dependents are below 200 percent of poverty; UNY*Care will offer them a sliding scale subsidy from $2,700 to $0. The exact amount of the subsidy will depend upon the person's income level between 100 percent and 200 percent of poverty and whether the policy holder is purchasing family or individual coverage. The subsidy will be provided to people currently uninsured, as well as those who already have insurance, but who wish to purchase a UNY*Care policy.

- **UNY*Care approved policies of $25,000 of inpatient care and $25,000 of major medical coverage will be made available to the unemployed and those people "not in the labor force." A sliding-scale subsidy will be available for those people below 200 percent of poverty. These policies will also benefit from the stop/loss provisions previously described.**

The uninsured unemployed and the uninsured who are not in the labor force, and their dependents, make up 1.1 million, or 44 percent of the 2.5 million uninsured. UNY*Care approved policies will be available to the unemployed/uninsured and those people otherwise not in the labor force, and this coverage will include the stop/loss benefit. The state will provide subsidies to those currently uninsured (0.7 million people), as well as those who already have private insurance but wish to purchase a UNY*Care approved policy. The assistance will be from $2,700 to $0 and will vary by income from 100 percent to 200 percent of poverty and whether the policy holder is purchasing family or individual coverage.

- **To protect employees below 200 percent of poverty, UNY*Care will provide a tax credit to those low income employees who contribute a relatively large amount through withholding to the employer's purchase of health insurance.**

A tax credit is necessary to protect low income employees from making relatively large contributions toward the employers' purchase of health insurance. Low income employees who work for an employer who just begins to provide coverage under the employer incentive coverage program will contribute a maximum of $500 and $250 for family and individual coverage, respectively, and low income employees who work for an employer already offering a comprehensive plan might be contributing several hundred dollars through payroll withholding. UNY*Care does not provide a maximum cap on their withholding in order to avoid interference with pre-determined labor-management agreements. A contribution of only $500 or $250 can be excessive for extremely low income employees. Therefore, a tax credit will be available to employees below 200 percent.

- **Personal contributions by low income households for their health care will be limited on the basis of income. The maximum contribution will range from $0 for a household at or below poverty to a maximum of $1,000 for those at 200 percent of poverty.**

Personal or out-of-pocket contributions, by low-income households, for their health care, are limited under UNY*Care to protect these individuals and families from impoverishing themselves as a result of their medical care needs. Personal contributions of low-income households (those with income below 200 percent of poverty) are determined on an income-based sliding scale such that households

with income at 100 percent of poverty are not responsible for any contribution and contributions by those with income at 200 percent of poverty may not exceed $1,000.

Long-Term Care

The need for long-term care coverage is clear. The population requiring most of these services, the elderly, is increasing. The New York State Department of Commerce estimates that the number of persons 65 and over will increase 11 percent from 1980 to 2010, or an increase of 2,404,578 persons. The 85 and over age group will experience a dramatic 88 percent increase. Current Medicare reimbursement for long-term care is woefully inadequate as it addresses the acute, not chronic, health care needs of elderly New Yorkers.

As the state analyzes and develops an approach for financing long-term care, it is apparent that the absence of private insurance for these services requires solutions that are quite different from UNY*Care's approach to primary, preventive and inpatient care. Ideally, the responsibility for long-term care financing should be assumed by the federal government. A public program could avoid many of the problems with our mixed system of insurance for medical care. The development of a Medicare Part C program is one of the more widely discussed approaches.

In the absence of a federal solution, New York State must decide if its efforts will be aimed at developing a state long-term care insurance program or at stimulating the private insurance market. The most likely scenario would involve the expansion of private long-term care insurance based in part on the results of the Robert Wood Johnson Foundation's long-term care insurance demonstration project. The project is expected to provide information that addresses the current difficulties of the private insurance system in providing affordable long-term care coverage including poor actuarial information, limited risk pools, and high administrative and sales costs. Answers to these issues, an improved data base and proposed models for state long-term care approaches will allow for a more thoughtfully developed program of long-term care insurance.

If the long-term care insurance market is successfully developed and expanded, it could then be incorporated more fully into UNY*Care, with UNY*Care providing both a stop-loss benefit for all policies and subsidies for low income residents who purchase insurance.

Tax-Financed Approach to UNY*Care

The basic design for financing UNY*Care is based upon a mixture of public programs which are tax-based and an expansion of employment-based insurance. A completely tax-based approach to universal coverage cannot be easily adopted at the state level. However, some of the advantages of a tax-based system have been incorporated into UNY*Care's design.

Tax-based systems, depending on the kind of tax that is levied, are much easier to administer because by definition the use of public funds to finance coverage almost always implies that the insurance is public in nature (like Social Security or Medicare). If the tax used to finance the scheme is progressive, then the burden of sharing the costs of illness falls upon the entire tax-paying population, whether healthy or sick. This is the fairest and most efficient way to finance universal coverage.

Despite the benefits of a purely tax-based approach, it also brings certain disadvantages. One of its most notable is the magnitude of tax revenues necessary to support a totally tax-based approach at the state level. For example, the entire amount of revenue collected in 1988 in New York State taxes and fees is $26 billion. Each increase of $1 billion represents an increase of 3.9 percent in total tax and fee revenue. If personal income taxes were excluded, other tax revenues would have to be increased by 8.5 percent for the same $1 billion. The breakdown of components of total state tax revenue is summarized below:

New York State Taxes and Fees Fiscal Year 1988

Tax	Billions of Dollars	Percent of Total
Personal Income	13.9	54.3
Sales and Use	5.3	20.7
Business Taxes	3.5	13.8
Property Transfer	1.2	4.7
User, licenses, fees	1.7	6.5
TOTAL	25.6	100.0

Another option is to raise taxes to replace the employer contribution. The private sector employer's contribution to health care in New York is approximately $9 billion. This sum cannot be easily covered by taxes immediately; however, this sum could be raised gradually over a phase-in period.

A mixture of tax-based programs and employer-based insurance was chosen for UNY*Care's design because that is the basis of the current system, offering its familiarity and experience, and because the single payer strategy overcomes many of the current system's liabilities. More than 50 percent -- about $19 billion of $35 billion -- of the current health care delivery system is already tax-based in one way or another (Medicare collects $8 billion from payroll tax, Medicaid collects $10 billion from federal/state/local, etc.). Even the employer-based coverage is tax "assisted." UNY*Care will continue to use this tax-based approach and will even expand upon it somewhat to help finance some of the program's costs.

UNY*Care will also implement various measures to counter-balance certain inequities in the employer-based system of providing health insurance. For example, there is great variance among employers in the amount each one withholds from employees for the purchase of health care. In order to minimize and standardize this variance for low income employees, UNY*Care will provide a tax credit to those low income employees who contribute a large amount through withholding. There is also great variance in the benefits provided by employers in terms of varying levels of deductibles, copayments, covered services, and catastrophic care. UNY*Care will minimize these differences by helping low income people pay for deductibles, copayments, and uncovered but needed services. Furthermore, UNY*Care will standardize catastrophic coverage by providing a stop/loss benefit. The stop/loss will

act to minimize catastrophic risks for employers and begin to lessen differences between various experience-related policies. Minimizing the differences between policies is a first step toward making community-rating the norm for health insurance.

EFFICIENCY AND QUALITY IN A UNIVERSAL ENVIRONMENT

The rising cost of health care is widely acknowledged and has been addressed by a number of strategies, particularly for hospital-based care. There has been gradual movement towards more uniform payment rates for hospital inpatient services by the various insurers under the leadership of state regulatory authority. Still, government officials and providers face multiple payers, both public and private, leading to fiscal irresponsibility on everyone's part. The arena for generating costs -- the hospital or the physician's office -- remains local in nature while the sources of payment are spread among all levels of government and among many different private payers. To alleviate these inequities, UNY*Care will concentrate responsibility in the hands of one actor -- state government -- which will play a larger role in assuring that adequate resources are available to meet the state's needs and that all New Yorkers have access to appropriate health care services.

Several specific ways that UNY*Care will encourage greater efficiency and quality of care are highlighted below:

Efficiency

- A single payer authority responsible for setting rates of reimbursement for all health care services in New York State will be interposed between existing third-party insurers and providers. As the sole entity authorized to set rates of reimbursement, UNY*Care or state government will assume the role of the single buyer of health care rather than continue as one of the many payers of health care. As the single payer, government will have more market power to effectively negotiate reimbursement structures that better promote efficiency and assure quality.

- Shifting government's role from one of many payers of health care to the single payer permits the establishment and enforcement of a "health care budget," which offers the capacity for better and more equitably controlling medical care inflation and for shifting scarce resources to the areas of greatest need. A statewide health budget will allow for system-wide projections of anticipated resource needs, revenues and expenditures. This budget will also allow UNY*Care administrators, elected officials, affected interest groups, and consumer representatives to make recommendations for necessary adjustments in taxes, premiums and reimbursement levels. For the first time, the public and officials will be asked to examine whether the growth in the system is in line with available public and private resources.

- Movement to a single, uniform reimbursement methodology will also help constrain overall health care costs. This is suggested by past experience with hospital reimbursement in New York State. The hospital reimbursement methodology, in effect since 1983, has resulted in inpatient care expenditures lower than the national average. To achieve system-wide savings all payers and all settings must be subject to uniform reimbursement methodologies and rates determined by a single payer, the state.

- The heart of the UNY*Care idea is to build an integrated, automated billing and payment system, one that, because it exploits advanced computer and information technology, operates as if it were a single payer, despite the continued existence of multiple payers. Toward this goal, the current billing and payment system will be streamlined. Aggregating claims submissions and provider payments through the single payer, or its agent, offers many advantages. Providers will interact with just one agent -- not multiple payers with multiple rules and procedures. The high rate of billing errors will be reduced as will the amount of resources needed to correct those errors. Similarly, we can eliminate the duplicative system that requires providers and payers to record essentially the same claim information. The exchange of utilization control information between provider and payer will be made more efficient. Also, by centralizing the flow of claims, the difficult task of coordinating benefits among myriad payers will be eased. Finally, UNY*Care can assure the timely flow of cash from payers to providers. The single payer mechanism enables each payer to deposit, on a regular basis, a pre-determined amount that reflects a portion of its expected billings. Then, the single payer can regularly deposit pre-determined amounts in each provider's account, making claims adjudication less central to the timely flow of funds.

- The projected efficiencies and improvements in the health care delivery system due to the creation and implementation of a reformed billing and payment system will be tested through a multi-county regional demonstration project.

- UNY*Care will encourage the development of capitated health care programs. One of the major barriers to the development of such programs has been the financial risk associated with catastrophic illness. The UNY*Care program's state-financed stop/loss will eliminate this financial risk, thus encouraging the development of these programs.

- Case management will be encouraged under UNY*Care. Case management may be defined as utilization of a primary care "gate-keeper" responsible for determining a patient's utilization of more sophisticated medical technology or specialty services to ensure that such services are utilized appropriately and effectively. A second aspect of case management is the guidance of persons with multiple, simultaneous needs through the health care system. Both of these aspects of case management will be encouraged, where appropriate, under the UNY*Care system.

HMOs As Part of UNY*Care

The role of HMOs in UNY*Care has not been adequately discussed, thus far, in this document. The economies and efficiencies of HMOs and managed care can be promoted through the UNY*Care structure. Alain Enthoven, a member of the Advisory Committee on Universal Access, has asked us to note his well known position that the health care finance system should include incentives to employers and others to join HMOs and other managed care plans that offer efficient and economic coverage. Although this could be controversial given its impact on labor-union collective bargaining agreements, it is fundamental to a system where government will be subsidizing the purchase of insurance. Clearly, incentives that encourage the use of managed care should be included to ensure that funds are most effectively spent.

Equally important, it must be noted that flexibility within the UNY*Care structure regarding HMOs is necessary since HMOs are both providers and insurers and, therefore, require a different stream of payment than other providers and insurers. HMOs actually could accommodate more readily the periodic predetermined transfers of funds envisioned as part of UNY*Care, thereby allowing them continued flexibility.

Quality of Care In a Universal Plan

"Quality" health care is often thought to refer to care provided according to accepted standards of practice with outcomes consistent with a person's condition. There is a wide array of Department of Health surveys, inspections, and other activities for surveillance of the quality of care delivered in most treatment settings and UNY*Care will improve the database needed to perform those activities. In this document we have also been discussing quality as very much tied to access and appropriate, timely use of services. The burdens on hospitals of persons with poor primary care, the persistence of certain causes of morbidity and mortality because of this same deficiency, the need to better target categorical programs and other resources, and so on, are quality issues. Thus, for quality of care, universal coverage must be provided within an overall framework capable of giving us greater ability to use services and resources judiciously and appropriately as part of making them more available. UNY*Care gives us this framework.

Access

An insurance mechanism alone will not overcome the barriers to health care, and will not be sufficient to assure all individuals access to care. In some urban and rural areas of the state, the supply of providers is insufficient and in many cases, inappropriate sites of service delivery offer the only available providers. For example, many inner city residents utilize hospital emergency rooms for primary care and other needs more appropriately met in clinics or physicians' offices. In rural areas, geographical barriers to care exist and providers are not always organized to meet most effectively the needs of the residents.

We recognize that these and other access issues must be addressed concurrently with the development of UNY*Care, and emphasize that the Department of Health will continue its efforts in this regard. UNY*Care's single payer/single buyer and its "health care budget" provide a powerful vehicle for the development of appropriate and organized health care delivery systems in areas with insufficient and ineffective provider supplies.

While UNY*Care is by definition and name a "universal" program, clearly there are a few groups in New York State for which the system may not guarantee access. In particular, questions have been raised about undocumented aliens and those uninsured who do not choose to enroll in UNY*Care or pay for any health care costs. Further discussion with the federal government is needed to most fairly meet the health care needs of undocumented aliens since they are disproportionately represented in New York State. Currently, undocumented aliens can receive Medicaid-covered emergency services, prenatal care and delivery in New York State. It would appear at this time that bad debt and charity care funds will continue to be necessary for their care for services other than those covered by Medicaid.

Additional work also remains on how residents can be encouraged to participate in UNY*Care; this will take the form of education and outreach and possible financial incentives or disincentives which would encourage the purchase of insurance. In any case, the continuation of some type of bad debt and charity care pool must remain to cover the health care needs of the remaining uninsured who present for health care.

CONCLUSION

Given the premise that all residents of New York should have access to health care, we must achieve this not through tinkering with some of the parts -- but through the recognition that cost control and universal access are inextricably linked and each is a prerequisite for the other. UNY*Care's basic components -- universal access, a single payer, a central claims processor, a standardized benefit package, employer responsibility and enhanced public programs -- taken together will achieve control over the growth of the system and the assurance that all residents will have equal access to quality health care.

APPENDIX

UNY*CARE ADVISORY COMMITTEE

SUMMARY OF COMMENTS

The UNY*Care Advisory Committee was created to provide advice and input regarding the September 1st proposal for Universal New York Health Care (UNY*Care), and to recommend changes or alterations where necessary. Committee members are listed below. The Committee, which met three times – September 27, November 2 and December 1 – provided invaluable independent review and criticism of the UNY*Care proposal. In some cases, the committee recommended further research.

Raymond J. Baxter, Ph.D.
Acting President
NYC Health & Hospitals Corp.

Howard Berman
President, CEO
Rochester Blue Cross/Blue Shield

Warren G. Billings
Executive Director, Health Services
State Communities Aid Assn.

Laurence D. Brown, Ph.D.
Professor
Columbia University

Maria Josefa Canino
Assistant Professor
Rutgers University

Alain Enthoven, Ph.D.
Marriner S. Echols Professor
of Public & Private Management
Stanford University

Deborah Freund, Ph.D.
Chair of Faculty of Health
Sciences and Administration
University of Indiana

Rashi Fein, Ph.D.
Professor
Harvard Medical School

Jerome M. Goldsmith, Ed.D.
Executive Vice President
Jewish Board of Family and
Children Services

Robert Gumbs
Executive Director
HSA of New York City, Inc.

Robert Haggerty, M.D.
President
The William T. Grant Foundation

David R. Jones
General Director
Community Service Society

Clarence F. Michalis
Chairman
Josiah Macy, Jr. Foundation

James Morone, Ph.D.
Associate Professor
Brown University

Joseph Newhouse, Ph.D.
Professor
Harvard University

Howard Newman, J.D.
Dean, Graduate School of
Public Administration
New York University

Elena Padilla, Ph.D.
Professor
New York University

Richard Shinn
Executive Vice President
New York State Exchange

William Streck, M.D.
Director
Mary Imogene Bassett Hospital

Kenneth Thorpe, Ph.D.
Assistant Professor
Harvard University

Eugene Vayda, M.D.
Professor
University of Toronto

The UNY*Care document was circulated to all committee members before the first meeting. The first meeting was devoted to discussing the general reactions of the committee to the proposal. These reactions were summarized by DOH staff and formed the basis of future discussions at the two subsequent meetings. The four principal areas of concern were:

- the impact of the proposal on business;
- the need for more access beyond insurance;
- utilization restrictions; and
- the functions of the single payer and its impact on private insurance.

Most Committee members seemed in agreement with the fundamental assumption behind the design of UNY*Care: universal coverage necessitates fundamental reforms in the reimbursement and payment system, and vice versa.

One member of the Committee questioned this assumption. Indeed, according to this member, if the problem is the lack of access for 2.5 million uninsured, why take on the responsibility for changing health care financing and reimbursement for all New Yorkers? Why not address this problem directly?

Without claiming that no other member shared this view, it seems fair to say that most members accept the thesis that expanding coverage must be accompanied by a reform of cost control mechanisms. Although all members of the Committee raised a

number of important issues and provided suggestions for improvement to the proposal, the group seemed to agree with the statement of one of their colleagues that perfecting the proposal must come to an end. The real challenge is changing the current system.

The following represents a summary of their comments to us on the initial version released September 1, 1989. The Committee was asked to comment on and make changes to this summary; six members did submit comments and the essence of those comments have been added to the summary that follows. We have benefitted greatly from the Committee's input and have incorporated many of their recommendations into the revised UNY*Care proposal of May 10, 1990. We hope that we can call upon them in the future to help us to further refine the proposal.

BUSINESS IMPACT AND INCENTIVES

While several members of the Advisory Committee pointed out the advantages of a tax-based system of universal health insurance, it was generally agreed that a program based on the existing system of employer-based coverage is the most realistic means of implementing an effective and efficient system of universal coverage. Members also agreed that businesses would be supportive of a proposal for universal coverage that controls costs more effectively. The majority of businesses that already provide coverage would probably welcome measures to assure some financial contribution from those businesses not providing coverage. Nevertheless, despite business suspicion of most forms of government regulations, several suggestions regarding specific components of the proposal were offered by committee members to make the package more attractive to business.

Several members voiced concern regarding the impact of the required employer contributions for employee health care on small and/or marginally profitable businesses. Arising from this concern were questions relating to alternative means of targeting subsidies to such firms to assist them with the costs of employee health benefits. Members suggested making subsidy amounts a function of firm profitability or total payroll although they also recognized the difficulty of determining which businesses are genuinely in need of a subsidy.

To help employers to more accurately forecast required health care contributions under this program, it was suggested that an upper limit on a firm's potential liability be established. Also, to generate revenues more equitably and avoid creating incentives for employers to lay-off part-time workers, it was recommended that employer's contributions be calculated as a percentage of their wage base rather than a contribution per employee. The September 1, 1989 UNY*Care proposal recommends that the employer's contribution be calculated as a set percentage of wages up to a predetermined cap (for example 12 percent of $14,000) per employee for all workers, both full and part-time. Using a percentage of wages gives employers the option of either buying a policy or paying the tax for part-time employees. Thus, the employer will be able to estimate its annual liability under this program and the incentive to lay-off workers, particularly part-time employees, will be minimized. Employers that provide insurance will receive a tax credit for the average cost of insurance per employee.

Some members suggested implementation of a program similar to that adopted in Massachusetts raises questions of equity. By capping the wage base (at, for example, $14,000), firms with lower-paid employees are taxed more harshly than firms with a larger wage base. As an alternative, we may want to investigate the possibility of taxing firms at a set percentage of the entire wage base. Under this scenario, the actual percentage of the wage base could be lowered (for example, from 12 percent to 10 percent). The result would be that firms employing low-wage workers would be hit with a less harsh tax. Further, the tax could be structured such that firms providing employee health benefits receive a tax credit for the average cost of insurance per employee minus a small percentage, for example .5 percent, which would be used to help subsidize health insurance costs for firms with low-wage workers (or the remaining uninsured).

An additional concern of several committee members related to how out-of-state employers with employees residing in New York State and conversely how New York State employers with out-of-state employees will be dealt with under this program. For employers located outside of New York State, UNY*Care will not have the authority to impose taxes. New York residents who are employees of out-of-state firms that have coverage that meets UNY*Care defined standards will be issued a UNY*Care card and thus be made a part of the overall system. These individuals will be eligible for subsidies if their income is below 200 percent of the federal poverty level. Employees of out-of-state firms that choose not to offer employee health benefits will have the option of purchasing a UNY*Care approved policy and will thus be eligible for subsidies if their income is below 200% of the federal poverty level. New York State employers with workers who reside out-of-state will be required to pay, like all other businesses in the state, the payroll tax for these non-resident employees.

It was suggested that there may be areas of New York State in which an employer will be able to purchase UNY*Care approved policies for less than the estimated policy cost used in the UNY*Care proposal. The concern was that if an employer is able to procure employee health insurance for less than the amount of the payroll tax, some employers would end up being taxed unfairly, in an amount greater than their cost.

The adequacy of the proposed subsidies to businesses was questioned by some committee members. It was suggested that the subsidies must cover a significant portion of the new cost to businesses if they are to support the UNY*Care proposal. Additionally, it was suggested that the subsidy for each employer be phased-out on a flexible schedule that recognizes each employer's financial status.

FISCAL ESTIMATES

Overall, advisory committee members found the fiscal estimates to be carefully constructed. There were, however, concerns regarding the data bases utilized, estimated policy costs, the proposed sliding-scale subsidies and the modeling technique employed.

Several members suggested that an independent actuary be contacted to evaluate the cost of a UNY*Care sponsored policy. It was thought that an independent evaluation would lend additional credence to our fiscal estimates. Similarly, the corporate community will be more likely to take the proposal seriously because businesses could more accurately gauge the cost impact of the UNY*Care policy standards on their taxes, health benefits, and subsidies.

Committee members also suggested that utilization of the Current Population Survey (CPS) as the basis for the population estimates may result in an undercount of the number of indigent New Yorkers. UNY*Care's fiscal estimates attempt to correct for this potential undercount by adjusting the number of Medicaid recipients reported by the CPS to more closely reflect the number of Medicaid recipients reported by the NYS Department of Social Services.

Several committee members requested that UNY*Care administrative costs be calculated and presented as part of the overall fiscal estimates.

As an alternative to the static modeling technique employed to derive the UNY*Care estimates, utilization of dynamic modeling techniques was recommended. Such modeling may alter the fiscal estimates by as much as 30 to 40 percent.

Finally, several members requested that the UNY*Care costs be compared and contrasted with overall health care expenditures in NYS. This comparison will provide readers with a reference point for comparing current health care expenditures in New York State to estimated expenditures under the UNY*Care program.

ACCESS TO HEALTH CARE AND THE HEALTH CARE DELIVERY SYSTEM

A crucial means for assuring access is universal coverage through the use of a universal card. While advisory committee members generally agreed that UNY*Care's insurance vehicle would increase access to health care in general, many members stated strongly that financial access alone would be insufficient to assure all individuals access to care. In some urban and rural areas of the state, the supply of providers is insufficient. In many cases, inappropriate sites of service delivery offer the only available providers. For example, many inner city residents utilize hospital emergency rooms for primary care and other needs more appropriately met in clinics or physicians' offices. In rural areas, geographical barriers to care exist and providers are not organized to most effectively meet the needs of area residents.

The current health care system can only attempt to address service shortages in a limited and piecemeal manner. UNY*Care, with its single payer/single buyer, establishes the framework to more effectively support the development of appropriate and organized health care delivery systems in areas with an insufficient and ineffective provider supply. Attention must be paid to the fact that only paying physicians more will not result in their locating in areas of need unless supported by nurses and ancillary services also. Future versions of the UNY*Care document will be amended to include details on the additional steps the UNY*Care authority must also take to improve access.

Other concerns raised regarding access centered on financial costs to participants and the feasibility of effectively administering the program. Some members felt that the sliding scale, as currently structured, was not generous enough, particularly for those with income at or near 200 percent of poverty. However, others noted that UNY*Care could not resolve all problems of access; perhaps the sliding scale could be made more generous in subsequent years. Concern was raised regarding the administrative feasibility of the program of subsidies and cost of means testing. How would individuals know if they are eligible for a subsidy? What about the "notch-effect?" Members also suggested that the proposal should be more specific regarding explicit sites where individuals can access care (supply patterns).

While acknowledging that insurance coverage alone would not ensure access, committee members urged that the agenda for universal coverage should be moved forward. Universal coverage certainly would not hinder access; at best it could serve as a platform for capturing new resources to pay for improved access.

Accountability was stressed, including a single new agency to administer the program and to avoid inter-agency conflicts. Knowledge of who is accountable is also important for consumers when access to health care is a problem.

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UTILIZATION CONTROLS

The UNY*Care proposal should include more specifics on utilization controls, members pointed out, because the rise in the insured population under UNY*Care will most likely result in increased demand and because of the significance of controlling use of the health care system.

In general, UNY*Care will control utilization though its reimbursement methodologies, through the expansion of managed care and HMOs, and continued use of payer utilization protocols. However, UNY*Care's cost containment mechanisms are not totally based on price controls. Case payment methodologies limit utilization and price. The single payer authority in its "single buyer" role as rate-setter would be in an excellent position to influence hospital and physician behavior through its rate setting methodologies, which incorporate utilization controls. Congress' recent passage of a physician payment methodology for Medicare includes volume controls, a clear utilization control. UNY*Care's physician payment methodology will be strongly influenced by Medicare's approach and will likely include such utilization controls. Moreover, the current case payment methodology addresses the appropriateness and medical necessity of care as well as price. UNY*Care will incorporate this methodology, thus continuing these utilization controls.

HMOs were not explicitly discussed in the UNY*Care proposal. Additional information has been added and will be expanded in future versions of the document. Managed care must be an integral strategy of UNY*Care, and such care and the expansion of HMOs will be encouraged through UNY*Care's payment methodologies.

In reviewing UNY*Care's utilization control mechanisms, committee members discussed a number of areas. The first pertained to UNY*Care's primary focus on the demand for services. It was suggested that we explore utilization controls that focus on the supply side, as in Canada. For example, the supply of expensive new technologies is subject to strict government control as is physician supply, the latter of which is controlled through a requirement that 50 percent of all residencies be in the area of family practice.

A second area of concern regarding utilization control was the equity of using copayments as a means of controlling utilization. Committee members suggested that copayments have a greater impact on those consumers who are "price sensitive," those who are least able to afford health care costs. Thus, reduced utilization, as a result of copayments, falls unfairly on those who are least able to pay for services. Many members agreed that the actual value or effectiveness of utilization controls is unclear. Utilization controls were described as having two possible purposes: 1) to reduce overall program costs and 2) to assure the delivery of medically necessary, quality health care services. Although utilization controls are frequently applied as a means of reducing costs, some members viewed their impact as yet unproven. Members proposed that costs might be better controlled by linking reimbursement with provider performance as measured by established protocols. UNY*Care, with its single payer authority, could provide the data base for this effort. However, explicit utilization standards are incomplete. Thus, it was suggested that a commission be established to develop such standards.

It was pointed out that the utilization control methods in the current system exist to a great extent because a comprehensive, universal access system does not now exist. We must first implement a universal program, and then institute utilization control

mechanisms within that context. Finally, although the issue of utilization control is important, increased demand on the part of the newly insured is desirable as one member stated, and UNY*Care can absorb the demand because its intent is to rationalize the system and allocate resources away from unnecessary care.

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SINGLE PAYER AUTHORITY AND ITS IMPACT ON PRIVATE INSURANCE

The single payer authority was the most controversial and most discussed issue in the proposal. Most committee members found the concept of a single payer authority to be a significant advance in our thinking about universal coverage. Some, however, found the idea technically formidable, beyond the capacity of state government, and threatening to the private insurance industry.

In the discussion over this aspect of the proposal during the three meetings, the following points emerged: the single payer has two major roles – building an unified, integrated billing and payment system, and single rate setting or purchasing of health care. In terms of claims processing, the single payer authority does not change or relieve the responsibility of the ultimate payer; it changes the place to which the bill is sent from the provider and in some cases how it is sent and how it is paid (electronically). The term "single payer" does not mean the elimination of existing payers and their current tasks. Rather, the centralized claims processing function will streamline the current billing and payment system. Estimates of current administrative costs in this country range from 10 percent to 20 percent of the nation's total health care bill. Canada has a cost of about three percent (the absence of means testing in Canada's tax-financed system plays a big part in this low figure).

The single payer authority's role as a single buyer of health care will be the primary source of controlling medical inflation. The single payer authority as buyer is intended to negotiate health care reimbursement with all providers on behalf of all New Yorkers at a rate we can collectively afford. The single payer authority must also develop a statewide budget, considering the needs of the health care system as a whole, and make decisions regarding how best to allocate funds. The single payer authority is a mechanism, as one member pointed out, for equitably containing costs and reallocating some resources to areas of greatest need. This member also contended that people should not consider what the single payer will or will not save next year; rather, we must consider the longer term and what that might cost without UNY*Care.

One member stated that the electronic claims processing system envisioned for the single payer was an onerous if not impossible task and that the standardization of the insurance package left little or no role for private insurers. DOH staff, who have consulted with health claims experts inside and outside government, have concluded that such an electronic system is feasible. Indeed, part of its central tasks - electronic claims processing - is already becoming a reality.

Standardization of the insurance package is an integral part of UNY*Care. This standardization shifts the insurance industry more from differentiation by product to price, not unlike many other industries. In addition, UNY*Care would establish a minimum benefit package, not a single policy. Under the regional pilot projects, minimum benefit standards were established, yet five different packages were eventually agreed upon. This experience could certainly be replicated in UNY*Care. The authority will not sell policies, but will determine the benefit package and will contract with insurers for the sale of new UNY*Care approved policies.

Others offered alternatives to the single payer – utilizing Blue Cross open enrollment policies to provide coverage for the uninsured and an option under which the state would set payment rates only for the "UNY*Care plan," which would be made available to all interested individuals. This latter approach would allow for competition between UNY*Care and existing insurance products. Neither of these approaches includes the power of a "single buyer" to control system growth nor the standardization and efficiencies of a "single payer" claims processor.

Additional questions and concerns raised by committee members regarding the UNY*Care proposal include the following:

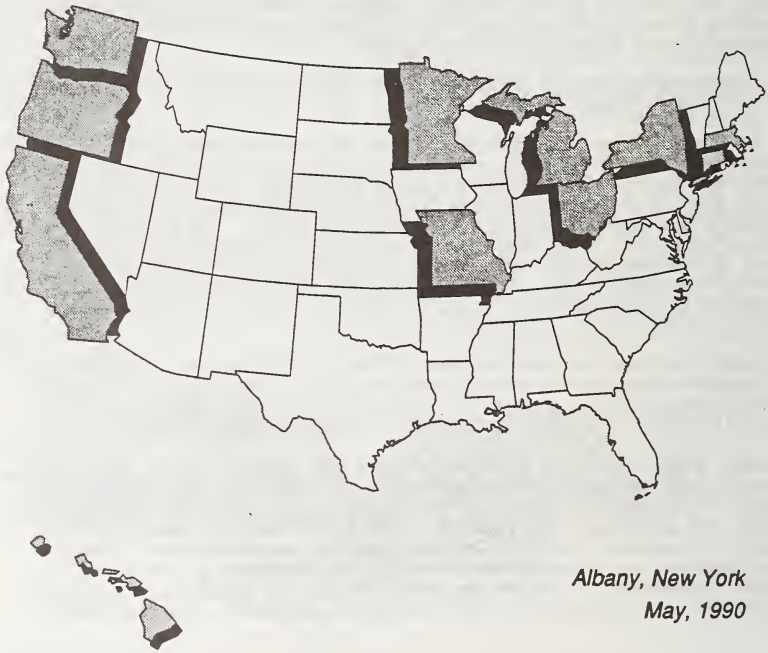
Several committee members requested further information regarding the recourse available to the UNY*Care authority in the event of non-payment of premium amounts or other out-of-pocket expenditures by program participants. The most immediate recourse available under this scenario is discontinuation of coverage and/or collecting the balance due through a collection agency or other efforts. It is hoped that the benefits of the program will provide inducement enough for full participation by all New Yorkers. It is recognized, however, that some individuals will "fall through the cracks," choosing not to participate and will remain uninsured. For these individuals it will be necessary to continue a bad debt and charity care pool similar to that which currently exists but of a much lesser magnitude.

Several committee members requested that the benefit package envisioned under UNY*Care be more explicitly defined within the body of the document. Precise definition of the components of the benefit package were purposefully excluded from the document to permit the program future latitude in refining the benefit package.

Other suggestions were made for changes and additions to the UNY*Care document. These include: clear goal statements; inclusion of the points of view and effects of UNY*Care on hospitals, doctors, insurers, etc.; description of phase-in activities and priorities; more specifics on how UNY*Care will affect HMOs; a mechanism independent from UNY*Care that providers can use to appeal utilization control decisions; and, changing the name "single payer authority" to a term implying a broader responsibility. It was also suggested the document stress that the proposal could simplify some of its more onerous tasks with the appropriate changes in Federal law.

Universal Health Care: Voices from The States

State Initiatives



Albany, New York
May, 1990

UNIVERSAL HEALTH CARE: VOICES FROM THE STATES

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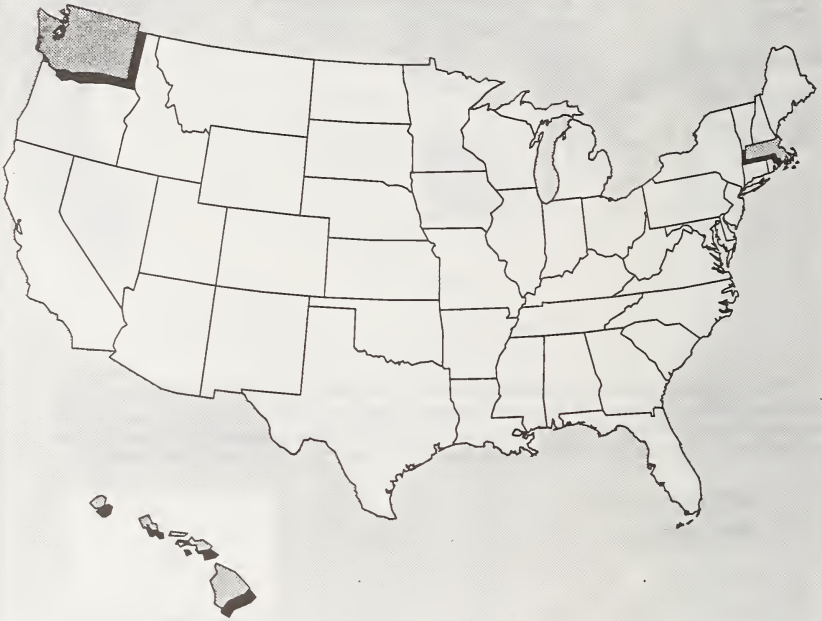
The following material summarizes the universal health care initiatives of the states presenting material at this conference. The first three were prepared by the individual states. The rest were prepared by New York State Department of Health staff with the close cooperation of each state, based on material submitted by the state.

Universal Health Care: Voices from The States

State Initiatives

Implementation Phase:

Hawaii
Massachusetts
Washington



HAWAII

Summary:

On April 16, 1990, Hawaii launched SHIP, the State Health Insurance Program, designed to make health care coverage universally accessible in Hawaii. It is likely that SHIP could not have come into being without the Prepaid Health Care Act. Passed in 1974, this measure mandates that, with certain limitations, all employers in the state must provide health insurance to their workers. The Act is administered by Hawaii's Department of Labor and Industrial Relations. While covering the vast majority of employees, Prepaid Health Care does not cover: the unemployed, dependents, persons working less than 20 hours a week, seasonal workers, students, and low-income/self-employed persons. The Act requires each employer to provide either fee-for-service or health maintenance organization benefits to its employees. Worker contributions are limited to 1-1/2% of monthly wages. The employer pays the balance and is only required to cover employee; dependent coverage is optional. Hawaii's Act was challenged in 1978 as being preempted by the Employee Retirement and Income Security Act (ERISA) of 1974. Hawaii received a federal exemption from ERISA in 1982 but the terms of the exemption limit Hawaii's law to the law that was in effect in 1974; thus, no changes to the law can be made.

Hawaii's Uninsured Population

In general, Prepaid Health Care can be credited for giving Hawaii the lowest rate of uninsured persons in the nation, an estimate which the Department of Health has placed at 5 percent. While the size of the total gap groups is estimated to be about 50,000 people, approximately 30,000 - 35,000 persons of low income do not have resources enough to finance their health care needs. The low income uninsured in Hawaii generally reflect the gaps in the Prepaid Health Care Act:

- At least 8,000 are school children;
- About 50% of the island of Oahu's unemployed lack coverage;
- Neighbor islands (other than Oahu) have higher rates; and
- Native Hawaiians and immigrants are high-risk groups.

The state has taken two major actions to bridge this gap since it cannot change the Prepaid Health Care Act. First, the state has broadened its Medicaid Program in response to newly enacted Medicaid options. Hawaii has utilized many of these options to cover more aged, immigrants, and has expanded benefits to pregnant women and children. The second answer to the gap lies in targeting the working poor who live above the Medicaid eligibility levels. This is the task of the new SHIP.

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Philosophy

The SHIP is directed to deal with the needs of the gap group. It is a flexible program which does not try to duplicate services already provided through Medicaid, Prepaid Health Care or any of the federal programs like CHAMPUS and Medicare. It is a temporary hand up for those who need help, most of whom will be fitting into the Prepaid Health Care System soon. It is seen as a partnership between the individual, medical providers, insurance companies and government. Because it addresses the hardest to reach of the working poor, it is necessarily outreach-oriented in philosophy.

Structure

While SHIP has a flexibility to utilize other mechanisms such as purchases of service from private providers, it is basically a health insurance program. SHIP will be structured as a fee-for-service system but it is hoped that a managed care system can be fashioned across the state for year two of the program.

The emphasis of SHIP is on preventive and primary care -- "health" insurance instead of "sickness" insurance. It thus focuses heavily on services such as health appraisals (well baby and well child care, age appropriate health screening), and basic primary care (12 physician visits a year, laboratory and x-ray, immunizations and other preventive procedures). Heavy cost items -- the secondary and tertiary care which drive up the cost of health insurance -- are de-emphasized in SHIP (the program provides 5 days on inpatient care and attempts to shift big cost items to Medicaid such as neonatal intensive care, end-stage renal disease care, open heart surgery, etc.) To carry out the program, SHIP is contracting with Hawaii Medical Services Association (HMSA), a Blue Shield organization, and Kaiser Permanente (an HMO). Costs of the program will be shared by the state and individuals. State general fund financing for the first full year is $10 million. Contributions by individual enrollees is projected at approximately $1.7 million. Monthly payments will be made on a sliding scale for enrollees, the enrollee share increasing with income up to 300% of poverty, the ceiling for the program. A small co-pay will also be required at the time of a visit ($5.00). We are targeting 150,000 enrollee months with a year end enrollment of 20,000 persons.

Enrollment Strategy

Two major policies guide SHIP's enrollment strategy. The first is to limit the barriers to enrollment. The second is to reach out and do aggressive outreach to bring people into the system.

Limiting barriers involves overcoming the natural bureaucracy that accompanies state programs. We have shortened application forms, eliminated asset requirements and have simplified entry to persons coming off Medicaid. SHIP has limited the number of administrative program staff. We have heavily emphasized involving current staff throughout the department, particularly focusing on public health nursing, a program which is statewide and which has many uninsured persons on its rolls already. Another strategy is to use volunteers both inside and outside the department to assist persons to enroll in SHIP. We have trained over 200 volunteers for this task. They will be helping persons at easily accessible locations such as supermarkets and other locations in the community. The program has bilingual capabilities and will be coming on-line with a computer touch screen to assist with enrollment later on in the summer. SHIP's initial enrollment period will last for seven weeks, running from April 16 through May 30, 1990. Succeeding enrollment periods will occur each quarter for at least one week.

Implementation of the program has gone expeditiously. Our enabling legislation has been broad, allowing a lot of flexibility in the development of the program. The Governor and his whole cabinet have provided strong support in mastering the administrative red-tape involved and in developing referral networks for SHIP within current state programs. Strong cooperation has also been evidenced through the health community as providers, insurers and public-spirited citizens have provided important backing for SHIP. Finally, the assistance that the state has enjoyed from the State of Washington's Basic Health Plan has been outstanding. Their willingness to share their program has given us the kind of head start we needed to make our basic target date. We owe Washington a great debt of gratitude and believe that the best way to evidence this is to provide whatever assistance we can to other states as we have been so much helped by Basic Health. We look forward to working with you all to foster innovation across the states and to resolve once and for all, the nagging problems of the uninsured.

MASSACHUSETTS

Summary:

In April 1988, Governor Michael Dukakis signed into law the Health Security Act, commonly known as universal health care. This law ensures that Massachusetts residents will have access to affordable health care by 1992. Despite reports to the contrary, the law is intact and implementation is on schedule. As this report describes, important steps have been taken to lay the foundation for universal health care. We expect that by the end of this year over 100,000 people will have been provided with medical coverage under the Health Security Act.

Phase-In Initiatives

Under the Health Security Act, the Department of Medical Security is required to establish phase-in initiatives to test different approaches to providing health insurance to the uninsured. The Department's goal is to test plans which are affordable and attractive to consumers, and at the same time cost-effective for businesses and the state. These programs are designed to gauge price sensitivity in the small business sector.

By the end of 1990 we expect to insure about 10,000 people through the phase-ins. The Department is contracting with HMOs and insurance companies in two rounds for FY90 phase-ins. In the first round, we have signed five contracts for comprehensive insurance plans, targeted primarily to businesses with less than 25 employees. For the second round, we have just issued an RFP asking for proposals for insurance plans with premiums at roughly $1680 per contract, the level of contribution required of employers in 1992. We have received five responses to this solicitation and we expect additional contracts to be effective in April. The Department has placed $11 million in a trust fund to support these contracts in FY90 by subsidizing premiums, sharing risk with the insurers, and supporting administrative and development costs.

Hospital Uncompensated Care Pool

The uncompensated care pool was created in 1985 to serve two purposes: to provide greater access to hospital care for uninsured individuals, and to distribute equitably across all hospitals the financial burden of serving these individuals. The pool is financed through an assessment on hospital bills paid by private insurers. Chapter 23 made two changes in the uncompensated care pool: it limited the private sector liability for pool charges -- for example, to $318.5 million in FY89 -- and it directed the Department to manage the pool beginning in October 1988.

In managing the pool the Department has followed two strategies. First, we have improved access to free care for people with limited incomes by expanding the eligibility limits to 200 percent of the poverty level for full free care and offering partial free care to individuals with incomes between 200 and 400 percent of the poverty level. Second, we have implemented rigorous standards to govern the maximum amount of bad debt that hospitals can charge to the pool. We estimate that the new standards will result in

approximately $40 million in savings to the pool, and thus to both the state and private businesses.

Unemployed Workers

In the Spring of 1990, unemployed workers who are receiving unemployment compensation will be eligible for health insurance coverage through the Department. We expect that roughly 325,000 workers will claim unemployment compensation from the Department of Employment and Training this year. A recent DET survey indicated that 40 percent of the claimants at any one time are without health insurance.

The planning and development for this program are on schedule. The Department will contract with one or more vendors to carry out all aspects of this program -- both administration and insurance coverage. A Request for Proposals was issued in January. The program will be funded by revenue generated by employer contributions to the Unemployment Health Insurance trust fund; beginning in January 1990, all Massachusetts employers with more than six workers are required to pay up to $16.80 per employee into the trust fund. We estimate that these contributions will generate $34 million in 1990.

Student Health Insurance

Chapter 23 required that all college and university students enrolled full three-quarters time be covered by health insurance by September 1989. This provision was implemented on schedule with few problems. All college students in Massachusetts must now either purchase health insurance through their institution or demonstrate that they are covered by a comparable plan.

We estimate that up to 55,000 students who did not have insurance before Chapter 23 are now covered. We also estimate that this coverage will result in up to $15 million in savings in the hospital uncompensated care pool.

CommonHealth

The CommonHealth program was implemented in July 1988 as the first phase of universal health care. Administered by the Department of Public Welfare, Common Health provides medical coverage to three groups: people who leave welfare to go to work, disabled children, and disabled adults who want to go to work.

Over 17,000 individuals have enrolled in CommonHealth to date, and the enrollment, especially of disabled children and adults, continues to grow.

CenterCare

In May 1989, the Department of Medical Security began a program called CenterCare to provide primary health coverage to uninsured people using participating community health centers. The Department pays the health centers a monthly rate tied to their enrollment.

Currently, over 5,300 people are enrolled in CenterCare in 23 health centers across the state.

Mandated Studies

One of the key elements of Chapter 23 is the directive to conduct a series of studies designed to gather systematic information on which to base policies and new programs. One mandated study, an analysis of the small business insurance market, is being released this month. This analysis, conducted by the Department of Medical Security and its Small Business Advisory Board, describes the problems small businesses face in purchasing health insurance for their employees, and highlights the need for insurance reform in order to establish a universal health care program. To follow up on this report, the Advisory Board and business organizations across the state are sponsoring public hearings in March to solicit ideas from business people and insurers about changing the small business insurance market.

A second mandated study, a survey of uninsured and underinsured Massachusetts residents, will provide a detailed picture of their demographics, employment, insurance, health status and access to health care. This study is currently underway and will be completed by April 1990.

Tax Credits

Beginning in January 1990, certain employers who begin to offer health insurance to their employees can claim a tax credit for two years based on the employer's health insurance premium costs. The amount of the tax credit is twenty percent of the employer's premium costs in the first year and ten percent in the second year. To be eligible for the tax credit, an employer must have 50 or fewer employees, not have contributed to their employees' health insurance premiums for three years and have contributed at least fifty percent of the costs of the employee coverage.

Constituency Development

Because the Health Security Act breaks new ground, it is important for the Department to work closely with a wide range of constituencies in implementing universal health care. During our first year of operation, we established and met regularly with two advisory boards: the small business advisory board and the uninsured advisory board. We also established and met with regional work groups across the state composed of representatives from a variety of businesses. Despite the newness of the Department, we also responded to an average of 75 calls a week from consumers and business people looking for information and assistance with their health and insurance problems.

WASHINGTON STATE'S ROAD TO UNIVERSAL HEALTH CARE

Summary:

Washington State has long been an innovator in health care. In 1909 it became the first state to adopt a no fault injured workers compensation program. Through the decades it has taken the lead in managed health care, health planning, and cost containment strategies. Over the past three years the state has pioneered several nationally recognized model programs, including: the Basic Health Plan (1987) and the High Risk Health Pool (1987) to provide access to health services for the uninsured; the Omnibus AIDS Act (1988) to provide a prevention and treatment framework to address that serious disease; the Maternity Care Access Act (1989) to provide needed prenatal care to low income women and health care to poor children; Rural Health Legislation (1989) to meet the health needs of rural communities; the Health Care Authority (1988), a single payer administration, to improve the efficiency of health benefit plans for public employees; and a state Department of Health (1989) to provide greater focus and leadership regarding health matters. During the 1990 Session, recently concluded, the Legislature expanded health coverage to include all children in poverty (HB 2603), established a statewide trauma care system (SB 6191), and exempted insurers from mandated benefit requirements when insuring employees of small businesses (SB 6834).

Although significant, these accomplishments are, for the most part, piecemeal attempts and have had limited success in addressing the pervasive problems of access, equity, quality of care, and cost control. Where 700,000 Washington state citizens were without health care access in 1986 that figure now approaches 800,000. (The Basic Health Plan, the state-subsidized program for the uninsured, is statutorily limited to 30,000 enrollees.) Washington State's health costs continue to rise unfettered. Presently $8 billion is spent annually and this figure is projected to reach $25 billion by the turn of the century, if major reforms are not implemented. For these reasons, Governor Gardner, many members of the Legislature, the health provider community, and citizens have called for a comprehensive reform of the state's health care system.

In response to the call for change, during this past session, three system proposals were put forth, two of which were prepared as legislation. There were also two bills that called for studies of the issue, however, much of the attention focused on HB 2252, the Washington Universal Health Access Act of 1990, referred to as the "Braddock Plan" after its prime sponsor Representative Dennis Braddock of Bellingham, Washington, Chair of the House Health Care Committee. Nevertheless, none of these were adopted into law. Ultimately, the Legislature, by resolution, created a commission to address the issue of access and cost.

The following is a summary of all the measures considered during the 1990 Session.

Health Care Allocation Study (SB 6737-Senator Madsen)

This measure required the Washington State Board of Health to conduct a study of access problems and report to the Legislature by November 1, 1991. The report would provide: a list of proven disease prevention and health promotion programs; a basic health package that should be available to all citizens; methods to hold health providers accountable, and an analysis of the medical malpractice problem.

State Health Care Access Task Force (SB 6270-Senator West)

Here, a health care access task force would be created of unspecified size to be appointed by the Governor to represent various groups interested in health care access. Staff assistance must be coordinated by State Board of Health staff.

The task force would conduct an analysis of the access problem, review the effectiveness of recent innovations to solve the problem in Washington, in other states and in other nations, and suggest a plan to ensure the availability of basic health care services. The analysis and plan would include a working definition of basic health care services, a specification of public and private entities responsible for implementation, a time line for phased implementation, estimates of cost and other necessary elements.

The task force's reports were timed to correspond with existing health policy development functions of state government including those of the State Board of Health and the state budget cycle. Preliminary reports were required in March of 1992 with a final report on June 30, 1992.

Comprehensive Health Care Coverage Act (SB 6020-Senator Talmadge)

The bill would have expanded the Basic Health Plan (BHP) to cover all persons whose family income is below 200% of the federal poverty level. To finance this expansion a 2% payroll tax up to $18,000 per employee, would be placed on employers, who could deduct as a credit any amount paid for their employee coverage. Physicians who treat Medicaid recipients in need of emergency OB care would be exempt from civil liability as long as done in good faith and without gross negligence. The state would indemnify physicians who provide OB care to Medicaid recipients for negligence claims in excess of $5,000.

Washington Health Access 2000 (Proposed By The Washington State Medical Association, But Not Introduced As Legislation)

Under this proposal, a commission would be created to define a minimal package of basic health services, which would be available to all residents by the year 2000. Medicaid would be made available to all residents with family income below the federal poverty level (FPL); persons between 100% and 200% of the FPL would be covered by the BHP by that year. Employers would receive a tax credit to provide coverage to those with incomes above 200%, but would be required to provide such coverage by the year 2000. A center would be created to develop professional practice standards promoting efficiency in health care.

Washington Universal Health Access Act Of 1990 ("The Braddock Plan" HB 2252)

As mentioned, most of the 1990 legislative health focus was on the Braddock Plan; the measure passed out of the House with bipartisan support, but was not fully considered in the Senate.

To address the issue of access and cost, HB 2252 would have created the Washington Universal Health Access and Cost Control Commission composed of 17 members including: four legislators; and representatives of business; unions; health providers; and citizens-at-large, including one senior citizen and one Medicaid recipient.

The main task of the commission would be to develop a universal health plan based on sets of plan principles and elements:

Plan Principles:

1) Citizens have the prime responsibility for their health status and, accordingly, should play a key role in the development of their health service system; 2) Appropriate health services should be available to all Washington State residents regardless of age sex, race, employment, health status, economic status, or place of residence; 3) A global state health services budget, established in a public manner, is necessary to control costs; 4) The burden for financing the health service system should be equitably shared by government, employers, and citizens; 5) Freedom of choice is important from both the perspective of the patient choosing a provider and the provider choosing a practice setting; 6) Health service providers should receive fair compensation for their services in a timely and uncomplicated manner; 7) Illness and injury prevention and health promotion should be a major part of the health service system; and 8) Quality of care should be promoted through the establishment of effective health services and by the assurance of acceptable standards for health professionals and facilities.

Plan Elements:

1) A universal health plan for residents of Washington State, that shall include a uniform comprehensive set of basic health services that is defined through a public process, based on the best scientific information available, and determined to be effective in the prevention and treatment of illness and injury; 2) A single public or private administrative organization that shall have complete operational authority over the plan, and include a uniform budgeting, billing, payment, and data system; 3) A state health services budget that shall set forth a finite amount of funds for the purchase of all health services provided in the plan; 4) A financing system with funds from government, employers, and residents: Government contributions that will include all state and federal sources, e.g., Medicare, Medicaid, public employee benefits, and all others; employer contributions that are set on a per capita basis, with special consideration for employers with small businesses; individual premiums that are based on family size, with reduced or no premiums for low-income families. Employers will be permitted to directly pay employee premiums. The commission will study the appropriate use of utilization fees and include them in resident participation, if deemed appropriate; 5) Hospitals will be funded by annual hospital budgets based on historical data and adjusted semiannually. Health providers will have the options of being reimbursed by way of fee-for-service, capitation, or annual budget, however, there will be incentives to practice in cost effective managed health care settings. No extra or balance billing will

be permitted; 6) The plan will include portability provisions so residents will be covered when out-of-state; and 7) Long term care will be fully integrated into the plan.

The commission shall study the advantages and disadvantages of prohibiting care service contractors, and commercial insurers from independently providing health services included in the plan. This would not preclude such entities from independently providing services not included in the plan, such as, excess medical coverage or procedures not covered by the plan, nor unions negotiating for additional benefits.

The commission shall analyze all state and federal laws that would need to be repealed, amended, or waived in order to implement the Universal Health Plan.

The commission shall study issues relating to medical malpractices liability and recommend any remedial action necessary. This analysis shall address the desirability and feasibility of creating a publicly funded malpractice insurance program.

As an early step in the implementation of this act, an implementation plan shall be developed to place all federal and state funded health services under a single administrative organization by July 1, 1993.

Where We Stand

Although the Legislature did not adopt HB 2252 or any other reform measure, it did, by resolution, create a Commission to study the issue of access and cost (HCR 4443). The Commission structure is very much like HB 2252, however, its charge is not as prescriptive in the principles and elements to be considered. The Commission is to initially report in December 1990 with ways to make the public a more prudent purchaser of health care, and then periodically until December 1992 on the broader issues of cost containment strategies, development of an efficient and effective basic package of health services, plans for universal access, and remedies for medical malpractice problem. The Commission terminates on December 1, 1992. $200,000 was appropriated for its first year work.

Universal Health Care: Voices from The States
State Initiatives

CALIFORNIA

Summary:

In February, 1990 an Advisory Task Force to the Secretaries of the Business, Transportation and Housing Agency and the Health and Welfare Agency released a report regarding solutions for the growing percentage of California's population which are "unsponsored for payment of health related costs." This report was mandated by Assembly Bill #350 in 1989.

In response to the problem of 22 percent uninsured Californians, the report recommends a two pronged approach. The first mandates employer based coverage for all workers and their dependents. In addition, to insure affordability this report recommends establishing access to the California Medicaid system (Medi-Cal) for low wage employees, low income self employed, and low profit employers. This new option would subsume Medi-Cal and be called CAL-CARE. Implementation of this plan would require an ERISA waiver.

In order to implement the recommendations of the Task Force Report, Representatives Margolin and Brown introduced AB 3032 on February 20,1990. The bill was assigned to the Subcommittee on Health and Workers' Insurance of the Finance and Insurance Committee where a series of hearings is currently being held.

Assembly Bill 3032

Financing for Employer-Based Insurance (other than CAL-CARE)

Employer Responsibility

Every employer would be required to provide basic health care coverage to all employees and their dependents unless the employee has been employed less than three months, is otherwise covered as a dependent or is eligible for worker's compensation. Employers would be required to pay at least 75 percent of the premium cost for individuals or 50 percent of the premium cost for family coverage. Employer contribution for part-time workers would be pro-rata. According to legislation passed in 1989, any employer with less than 25 employees will be allowed a tax credit equal to 25 percent of the cost of health premiums paid for employees. However, legislators are currently considering decreasing the amount of this credit and directing the balance available towards funding the subsidy portion of this proposal. Employers not offering coverage would be liable for "first dollar" health care costs for their uninsured employees, plus a penalty charge due to the state.

Employee Responsibility

Employees would pay 25 percent of the cost of premiums for individual coverage or up to 50 percent of the premium for family coverage. Part-time employees would

contribute a prorated share. All employees would be required to participate in purchasing at least a basic benefit plan.

"CAL-CARE"

The bill would rename California's Medi-Cal program, CAL-CARE and permit a wide range of residents to purchase health care coverage through CAL-CARE. They would include low and moderate profit employers, low income employees and their dependents and employees and dependents with no other available coverage.

The cost of CAL-CARE premiums would be set in statute and would be adjusted annually by the Consumer Price Index. First year monthly premiums would be:

Single adult	$ 84.80
Two person family	$168.11
Family of three or more	$278.11

These premiums would be subsidized for both employers and employees.

- Employers with annual profits per full-time employee from 0-$1,000 would be entitled to a subsidy of 60% and employers with annual profits of $1,000 to $2,000 would be entitled to a subsidy of 40%.

- Employees and self-employed persons with salaries below the FPL would be entitled to a subsidy of 60% and those with salaries between 100% and 200% of the FPL would be entitled to 40%.

Benefits

The mandated basic benefit package would include the following:

- 30 days of hospital inpatient care annually, including most necessary services for diagnosis and treatment
- Medical and surgical services on an outpatient basis when appropriate including diagnostic tests, radiation and chemotherapy, home, office and hospital visits by a physician and preventive services for the health maintenance of minors
- Comprehensive maternity and perinatal care
- Emergency care and transportation
- 100 days of skilled nursing and home health care
- Hospice services
- Plastic and reconstructive services for the purpose of correcting a functional disorder that is the result of either birth, disease, accident or associated with a mastectomy
- Mental health benefits, 10 days of inpatient per year plus 15 outpatient visits per year

- At least 10 outpatient visits per year for speech, occupational or physical therapy
- Well child care and preventive child dental services.
- Prescription drugs approved by the FDA

The following co-payments would be required for designated services:

- $5 for primary care office visit, excluding referrals, preventive care or maternity care
- $2 - $5 for outpatient prescription drugs
- $50 for inpatient admission excluding maternity care or readmission for the same condition within 90 days
- $25 for emergency room visits

The plan also lists a group of services that would not be included in the mandated basic benefit package. These services could be provided subject to labor negotiations and individual choice at extra cost.

CAL-CARE recipients who meet federal and state Medicaid eligibility requirements would receive the mandated minimum benefit package with the following supplements: long term care, unlimited hospitalization and durable medical equipment. However, this bill would eliminate the following benefits, previously covered under Medi-Cal: adult dental, eyeglasses, chiropractic and podiatric services.

Reimbursement Incentives to Increase Access

Assembly Bill 3032 would require the California Department of Health Services to allocate $640 million for rate increases to CAL-CARE providers. These would include a 35 percent increase for physicians, a $200 million increase for hospitals and $49.8 million increase for managed care incentives.

Currently, California is the only major state which prohibits hospitals from employing physicians and charging patients for their services. Assembly Bill 3032 would permit any licensed health care corporation to practice medicine. This would allow hospitals and skilled nursing facilities to employ physicians, thus increasing corporate competition among hospitals and increasing the number of private hospitals that participate in staff model HMOs. Additionally, PHPs serving CAL-CARE would be allowed to use specially negotiated hospital per-diem rates.

Insurance Reform

Underwriting changes would be made to guarantee affordable and available insurance. All insurers providing insurance to the small group market would be required to provide non-cancellable, guaranteed-issue policies to all small groups. In addition, the difference between the lowest and highest cost premiums offered would be limited. Insurers not providing coverage to small groups would be required to pay assessments to help cover the cost of small business insurance. All carriers would be prohibited from imposing pre-existing condition exclusions longer than six months.

Tort Law Reform

Bill 3032 would require various reforms in Tort Law designed to reduce the costs of "defensive medicine". These include the following:

- Immunity from civil action for simple negligence for emergency care provided by a physician to a patient with whom the physician does not have a patient relationship and when the physician has no reasonable expectation of compensation.
- Increased use of mediation and arbitration prior to litigation for covered services.
- Penalties for lawyers not exercising reasonable inquiry prior to taking legal action.
- Reimbursement by responsible third parties to health insurers for all injury related medical expenses.

Other California Health Care Initiatives

- California recently expanded Medi-Cal eligibility.
- California's legislature recently established a risk pool, a state sponsored health plan for people who have been denied health insurance because of pre-existing medical conditions. Benefits will be subsidized by state tobacco tax dollars. Premiums will be 125 percent of standard risk individual policies.
- A program of tax credits encouraging small employers to offer health insurance has been recently enacted. Participation in the program is voluntary.
- A bill currently in the legislature would mandate employers to provide coverage for employees. The proposal would apply to firms that employ five or more workers, would cover employees working 20 hours per week or more and would not require dependent coverage. This would require an ERISA waiver.
- Another proposal under consideration proposes universal coverage through a payroll tax. Employers would pay approximately 8 percent of their gross payroll and receive a tax credit. Persons not directly covered by employers would have withheld from their pay a health insurance premium equal to 25 percent of the cost of the plan. With revenues from the payroll tax plus other tax revenues, the state would purchase health insurance from contract health plans. Medi-Cal families would be able to participate in this program if appropriate federal waivers were granted.
- Health Access, a statewide consumer coalition has proposed a total reform of the health care financing system in California. Under this program, health insurance coverage would not be tied to employment, but would be financed through an entirely tax funded system. All state residents would be covered under one program and a wide choice of providers and health plans would be available. This system would reduce employer's costs and shift the financial burden from the regressive system of premiums to a progressive tax system based on ability to pay. This proposal may appear as a ballot initiative in the state of California in 1992.

MICHIGAN

Summary:

There are at least two legislative proposals available for consideration during the 1990 Michigan legislative session that address the need for universal health care. The Universal Health Care Insurance and Safety Net Act proposes an employer-based insurance fund that would also provide benefits to the Medicaid and General Assistance populations. Regional administrative boards would have major responsibility for program design. The MICHICARE plan proposes a tax-financed system with a full range of services including mental health and institutional and community-based long term care.

Michigan has recently undertaken five initiatives to secure access to health services for the uninsured and the underinsured. These include the Governor's Task Force on Access to Health Care formed in 1987 to assess the degree to which financial barriers prevent ready access to needed health services; the Health Care Access Project (HCAP) which is designed to increase the receipt of employer based insurance especially among former welfare clients; an expansion of the designated services under the Basic Health Services Act of 1978; Healthy Start, a health care coverage program for children under age ten from modest to low income uninsured families; and the Small Business Initiative, a program designed to make health insurance more accessible to small businesses in Michigan.

1990 Legislative Initiatives

The Universal Health Care Insurance and Safety Net Act (SB97)

This Bill, introduced by Senator John Kelly would create a Universal Health Care Fund financed equally by employers, employees and the state to provide health insurance benefits for the working poor and their families and Medicaid and General Assistance recipients.

A ten member advisory board would develop model health plans and make recommendations regarding actuarial equivalency and cost-benefit analyses of health benefit plan options.

The insurance fund would be administered by regional boards, each representing a multi-county universal health care insurance fund zone. Zone boards would be allowed great latitude in their administrative activities ranging from assuring an adequate supply of providers to running zone-wide preferred provider organizations or health maintenance organizations.

Financing

- Employees not currently participating in a health benefit plan would be required to pay a 3 percent withholding tax from their taxable income to the health insurance fund.
- Employers not currently providing a health benefit plan would be required to pay an amount equal to 3 percent of each employee's taxable income to the health insurance fund.
- The state would contribute an amount equal to 3 percent of each employee's taxable income to the health insurance fund in the insurance zone where the employee works.
- The state would pay an amount equal to 9 percent of the average taxable income of participating employees for each Medicaid and General Assistance recipient in an insurance zone.

Penalties for Noncompliance

Employers failing to comply with the act could be fined 10 percent of their total wage base for that year plus an assessment to cover all back contributions of the employer, employees and the state. In addition, employees would be able to recover health care costs from intentionally noncompliant employers.

Eligibility

- All employees working at least 17.5 hours per week and being paid minimum wage, or less if the law allows, would be eligible to participate in this fund. New employees would be eligible 30 days after their first hour of service. Temporary employees would be eligible after completing a given amount of consecutive hours of work.
- No employee could waive enrollment for themselves or their dependents unless they are otherwise covered.
- No employee could be excluded based on previous conditions.

Benefits

Benefits under this Act include:

- Inpatient and outpatient hospital care
- Inpatient and outpatient physician care
- Diagnostic and screening tests
- Prenatal care
- Well-baby care up to one year old
- Mental Health care (if elected by employer) up to 45 days inpatient or not less than 20 visits outpatient.

Deductibles for the first year would not exceed $150 for individual or $250 for family coverage. In subsequent years deductibles could be increased by the percentage increase in the Detroit CPI.

Coinsurance payments for covered services could not exceed 10 percent of the cost of the service unless the enrollee uses nonparticipating providers or does not comply with reasonable utilization review procedures.

Both coinsurance and deductibles could not exceed $1,000 or, alternatively, 10 percent of total wages paid to the employee in the plan year. This limit would also keep pace with the Detroit CPI.

Administration

Universal health insurance zones would be established either as single or multi-county entities based on population. Each zone would have a board of directors consisting of 9-13 members. Contributing employers and employees would elect a given number of members with county governing bodies appointing others. The chairperson would be appointed by the Governor.

Each board would administer the zone's universal health insurance fund with the following responsibilities:

- Selection and oversight of participating insurance providers in the zone.
- Designation of hospitals, clinics and other service providers in the zone.
- Evaluation and recommendation concerning coverage and programs offered by the fund in the zone.

"MICHICARE"

Representative Perry Bullard is planning to introduce MICHICARE, a Canadian style universal health care plan supported by a tax-financed system. This plan would provide insurance for all residents regardless of income or employment status. It would feature a single payment authority, comprehensive benefits and global budgets for hospitals.

Michigan Program Initiatives

The Governor's Task Force on Access to Health Care

Formed in October, 1987, the task force was given two charges: (1) to assess the degree to which financial barriers prevent Michigan citizens from receiving needed health care and (2) to recommend an overall state plan dealing with access to health care. The Task Force was composed of forty members representing diverse constituencies and was assisted by an Academic Consortium composed of faculty from four major universities in the state.

Although Task Force members were initially challenged by their different perspectives, over the two year meeting period they achieved consensus on the need for

a universal health care plan that would assure access to quality health care for all Michigan citizens.

The Task Force approved seven recommendations that would broaden health care access and lead to a universal plan. Four of the recommendations address the need for a universal health care plan which is technically and fiscally feasible and achieves cost containment objectives. The Task Force preferred a federal or federal/state plan and recommended work with the Michigan delegation to achieve that end. However, In view of the uncertainty of federal action, the Task Force recommended development of a strategy for phased-in implementation of universal health care. Implementation should include:

- Public and private initiatives to improve access for children
- Expansion of Medicaid to include a wider definition of the disabled population, and
- Development of programs to assist small employers in obtaining reasonably priced health care coverage.

The fifth recommendation advised the Task Force, in pursuing further work, to consult with the Governor's Health Care Cost Management Team and the Special Fact Finder to the Governor on the malpractice problem. The final two recommendations addressed the need to continue education and consensus-building to secure broad support for the Task Force's actions and the need to continue adequate funding for the Task Force and its staff for the next 18 months.

Health Care Access Project (HCAP)

The HCAP was designed to determine the extent to which subsidizing employer health insurance cost would increase the number of persons with employer based insurance. This project was also designed to increase the chances that a welfare recipient would get a job which offered health insurance. A major project under the Robert Wood Johnson Foundations' Health Care for the Uninsured, HCAP receives financial support for medical care from another foundation, a state agency and two counties. This project has two major components. The One Third Share (OTS) Plan encourages the purchase of health insurance by small employers. The second component involves a new health care delivery system for persons on welfare.

Under the OTS Plan, the project pays one third of the cost of health insurance for small businesses employing persons whose wages are below 200 percent of poverty. The average participating business has between five and eight employees. Through HCAP approximately 600 employees and their dependents have been offered insurance for the first time.

The second part of HCAP streamlined the delivery of health care to persons on welfare by implementing a managed care delivery system. Each welfare recipient receives a medical identification card and enrolls with a physician sponsor. To encourage physician participation, reimbursement was increased from General Assistance Medical rates to Medicaid rates, an eighteen percent increase. The project also offers transition health coverage for former welfare clients who become employed.

Basic Health Services

Public Act 368 of 1978 provides statutory authority for the establishment of certain "Basic Health Services." A Basic Health Service is a "service to be made available and accessible to all residents in need of the services in this state without regard for place of residence, marital status, sex, age, race, or inability to pay." To date, ten services, including immunizations and prenatal care have been designated basic health services. A recent legislative initiative proposes designating family planning services as well as expanding the availability of such services to women up to 185 percent of poverty. In order to meet the family planning needs in the clinical, educational and community services areas for an estimated 169,000 women, over a period of three to seven years, approximately $1.95 million in additional state dollars will be required annually.

Healthy Start

This program guarantees good health care for uninsured children in working families of modest means. The program will provide doctor visits, hospitalization, wellness checkups, immunizations and other preventive services for children under age ten.

Small Business Initiative

The Independent Business Research Office of Michigan conducted a study of health insurance costs for small businesses in Michigan. The study found that small employers, (74 percent of Michigan's employers employ fewer than ten people), definitely face higher health insurance costs than employers with more than 500 employees. Premiums may be as much as 50 percent greater for small employers than for large self insuring employers offering comparable benefits.

As a follow up to this study, the Michigan Department of Commerce is analyzing a number of models to assess the feasibility of a joint health care purchasing arrangement for small businesses in Michigan.

MISSOURI

Summary:

House Bill No. 1127 introduced by Representative Gail Chatfield would create the Missouri Universal Health Assurance Plan which is basically modeled on the Canadian health care system. This plan would establish a single, publicly financed statewide insurance program that would provide comprehensive coverage for all necessary health care services for all residents of Missouri. Several other bills have been introduced to expand insurance coverage for Missouri residents.

Missouri Universal Health Insurance Plan

Financing

Employers would pay a health premium surcharge of 75 cents per hour for each employee for each hour or portion of an hour worked by that employee. Payment for salaried employees would be based on a 40 hour week.

Self employed would pay a quarterly health premium surcharge of 75 cents per hour based on the actual number of hours worked not to exceed 40 hours per week.

All Missouri residents would pay a health premium surcharge through their state income tax based on their adjusted gross income. This surcharge would range from zero for those with incomes under $5,000 up to 2 percent of incomes over $200,000. Employers would be allowed to pay their employees' surcharge if they so choose. This would not be counted as employee income.

Benefit Package

The Missouri Plan would cover any medical service "if the service is necessary or appropriate for the maintenance of health or for the diagnosis or treatment of, or rehabilitation following injury, disability, or disease." Thus, these services would include hospital and physician services, laboratory and x-ray, prescription drugs, home health care, hospice care, mental health benefits and limited alcohol and drug rehabilitation. Deductibles and co-payments do not apply.

Prohibited services include:

- Cosmetic surgery other than for reconstructive services
- Medical exams prepared for life insurance or civil action
- Custodial nursing home care

Persons currently covered under Medicaid and Medicare would receive their benefits through the new statewide program. Residents of other states who work in Missouri would be eligible for the plan if they pay the surcharge. Employers and insurance companies could offer additional benefits, but would be prohibited from offering any benefits that are covered under the Health Assurance Plan.

Trust Fund

The plan would create a Missouri Health Care Trust Fund. This fund would contain all federal monies received as a result of waivers granted from Title XIX of the Social Security Act, all monies appropriated by the General Assembly to the plan and all income from other sources. Various accounts would be created within this fund to be used for the following purposes: establishing and maintaining primary community prevention programs and screening tests, paying providers, supporting medical research grants and supporting the construction, renovation and equipment of health care institutions.

Separate from the health care trust fund and within the state treasury, a Health Professional Education and Training Fund would be developed. This fund would consist of all federal monies received for such training and would be used solely to pay for the education and training of health professionals who contract with the governing board to practice in Missouri for a minimum of five years following graduation.

Reimbursement

Providers would be reimbursed as follows:

Global Budgets negotiated annually with all inpatient institutions to cover anticipated services and necessary construction, renovation or equipment purchase.

Fee for Service schedule annually negotiated would be used to reimburse independent providers. Negotiations between the Plan and the appropriate professional group would set the fees each year.

Capitation reimbursement could be chosen by multi-specialty provider organizations in lieu of fee for service.

Administration

The Missouri Universal Health Assurance Plan would be administered by a board of governors composed of 21 members. Board members would represent a variety of public health professions, a cross section of consumers, labor and business. Six ex-officio members would include the directors of pertinent state departments.

This board would meet a minimum of six times per year and would establish budget and policy, develop fee schedules, determine capital expenditures, approve coverage changes and administer and implement the plan.

Other Missouri Legislation Addressing the Needs of the Uninsured

- Two bills introduced this January, one to the Senate, the other to the House of Representatives, would require insurance companies to expand coverage to

vulnerable populations. The first, H1465, would require all health insurance policies to provide coverage for child health supervision services for children aged birth through 12 years. Benefits would be exempt from co-payment, co-insurance, deductible or dollar limits contained in the policy. The second, S691, would require insurers to offer prenatal care and child health supervision any time they deliver, renew or extend any health insurance policy. In this bill, benefits would be subject to the same limits and deductibles as any other health insurance policies.

- A house bill introduced on January 16 would require employers to provide or pay for health insurance benefits for their officers, full time employees and part-time employees who work at least 20 hours per week at least 3 months of any calendar year.
- Two bills introduced in the Senate would establish a Health Services Commission and Joint Committee on Health Care. These bodies would develop a benefit-driven prioritized list of health services similar to the basic Health Services Act in Oregon. The Joint Committee would devise a long range program for health services to low income persons.

OHIO

Summary:

House Bill 425, introduced in November, 1989 by Representative Robert Hagan would create UHIO, Universal Health Insurance for Ohio, a Canadian-style health care system financed through a series of taxes and administered by an appointed Board of Governors. All Ohio residents would be eligible to receive the covered benefits through this system with a wide choice of providers. Private insurers would be able to offer benefits not covered by the UHIO plan, but would not be permitted to offer any benefits that are covered. This legislation is currently in the Health Insurance Subcommittee of the House Committee on Insurance. Several other initiatives exist to assure health care coverage for Ohio residents.

Universal Health Insurance for Ohio

Financing

Revenue sources for UHIO would include:

- An 8 percent payroll tax on employers and the self-employed
- A 1 percent payroll tax on employees
- A 2 percent tax on interest and dividends over $1,000
- A 10 percent excise tax on harmful substances, e.g., tobacco and alcohol

Benefit Package

All residents would be free to choose their provider: an independent physician, small group or a large capitated practice.

Covered services would include:

- All medical services necessary for maintaining health or for the diagnosis or treatment of or rehabilitation following an injury, disability or disease with no deductible and no co-payment
- Pediatric dental services with no deductible and no co-pay
- All prescription medicine with $1 co-pay (adjustable every 2 years), no co-pay for welfare recipients

- An established number of annual mental health visits at no charge with possible co-payments for extended therapy
- One-per-year admission to a treatment facility for drug abuse

UHIO would not cover cosmetic surgery, medical exams for life insurance or civil action purposes or basic nursing home care. Employers and insurance companies could offer additional benefits that do not duplicate benefits already provided.

Trust Funds

All tax revenues would be deposited in the Ohio Health Care Trust Fund which would be administered by the Board of Governors. The Department of Human Services would apply to the federal government for waivers, allowing all federal programs making payments for health care services to individuals in Ohio, to deposit these payments in the Ohio Health Care Trust Fund. The following three major accounts would be established within the health care trust fund:

Prevention Account

Funds would be used for primary community prevention and to cover some of the expenses of proven preventive screening. Every 2 years the board would determine what percent of the trust fund should be dedicated to this account.

Health Services Account

Funds would be used solely to pay participating providers.

Capital Account

The Ohio Health Plan would develop an annual capital budget to support construction, renovation and major technology purchases.

In addition, separate funds would be set aside for the Health Professional, Education and Training Fund. For five years, the state would be prohibited from reducing state funds directed towards health professional training.

Reimbursement

Providers would be reimbursed as follows:

Global Budgets negotiated annually with all inpatient institutions to cover anticipated services and necessary construction, renovation or equipment purchase.

Fee for Service schedule annually negotiated would be used to reimburse independent providers. Negotiations between the Plan and the appropriate professional group would determine the fees each year.

Capitation reimbursement could be chosen by multi-specialty provider organizations in lieu of fee for service.

Administration

An Ohio Health Plan board would be responsible for the policies and budgetary priorities of the plan. Fifteen members would be appointed by the Governor for five-year terms. Ten would represent consumer interests and five would represent provider interests. Ex-officio members would include the Directors of the Health Department, Human Services, Insurance Department and Department of Taxation.

Other Ohio Health Care Initiatives to Address Needs of the Uninsured

- Expansion of Medicaid eligibility to children under one year and pregnant women with incomes under 100 percent of FPL as of January 1, 1989. As of April 1990, coverage will expand to children under six and pregnant women with incomes up to 133 percent of FPL.
- Ohio has funded four demonstration projects which are testing alternatives for providing affordable health insurance benefits to uninsured workers and dependents.
- The "Caring Program" matches private donations with funds from Community Mutual Blue Cross/Blue Shield of Ohio to meet the health care needs of low income children in families ineligible for Medicaid.
- Pending legislation would establish a health insurance risk pool to offer coverage to those who are unable to obtain affordable health insurance due to an existing medical condition. Premium rates would be based on family income and size.
- The General Assembly created a Task Force on Health Care and Health Insurance to study and make recommendations regarding the availability and affordability of health services and health insurance in Ohio.
- The Ohio Department of Insurance established a Health Insurance Task Force to review the state's health insurance crisis.

OREGON

Summary:

In 1989 the Oregon legislature passed two major pieces of health care legislation and a third piece which provided funding for an insurance risk pool for previously uninsurable citizens. The first two pieces, the Oregon Basic Health Services Act and the Health Partnership Act delineate responsibility for Oregon's 400,000 uninsured residents. The first establishes state responsibility to provide a minimum health benefits package through a Medicaid expansion covering all individuals under 100 percent of the Federal Poverty Level whether or not they are employed or otherwise categorically eligible. In the second, employers assume responsibility for all permanent workers and their dependents. Employees share in the cost of their health benefit premium and may contribute deductibles and reasonable co-payments as well.

Oregon Basic Health Services Act

The Health Services Commission, created by this legislation, will develop a prioritized list of health care services based on the beneficial outcome of each service or procedure. Benefit, in this context, will reflect both social values and clinical effectiveness.

Based on this list combined with actuarially assigned costs, the Legislature will determine the level of benefits the state can afford to purchase for all those under 100 percent of the Federal Poverty Level. This benefit package also defines the minimum package that can be offered by small employers who are eligible for the tax credit program established by The Health Partnership Act.

The state will contract with managed care providers to offer this package of benefits for a 1 year period.

This Basic Health Services Act is dependent on federal waivers for the Medicaid program which have not been granted, as of this writing.

Health Partnership Act

Financing

Employer Responsibility

Employers of 25 employees or less, which have not provided health care benefits for 2 years will pay 75 percent of the premium for each employee. The employer will be eligible for a tax credit equal to 50 percent of the total amount paid or $25, whichever is less. This applies to Part 1 of the benefit package. Part 2 provides dependent coverage and may include increased options such as optical, dental and lowered deductibles. The Insurance Pool Governing Board will negotiate with private insurers

to develop both Part 1 and Part 2 benefit packages. Tax credits will be reduced every year over a five year period unless certain numbers of previously uninsured persons are insured by dates specified in the Bill, in which case, tax credits are maintained at the original level for a longer period.

If fewer than 150,000 previously uninsured employees are insured by October, 1993, then all employers will be required to provide employee and dependent coverage by January 1, 1994. At that time, employers would pay at least 50 percent of the cost of dependent coverage. Coverage in 1994 must include Part 1 and Part 2. There would be hardship provisions for small businesses and an eighteen month waiting period for new businesses in 1994.

Employee Responsibility

Employees will contribute up to 25 percent or $15 per month towards a Part 1 premium. The legislation does not address the cost sharing responsibilities for dependent coverage under the voluntary employer-based program. If the mandate goes into effect in 1994, employees will have to pay up to 50 percent of the Part 2 premium, the amount of which is undetermined at this time. Employees must be working at least 17.5 hours per week and must have worked for the same employer for at least 90 days to be eligible for the program.

Benefits

Medicaid Recipients

The range of services considered during the prioritization process will include provider services and supplies, outpatient services, inpatient services and health promotion and disease prevention services. During recently completed surveys and public hearings, the Commission has been made aware that the Oregon community places a high benefit on preventive care, in particular. This will be taken into account as the Commission moves ahead with the prioritization process.

Exempt Benefits

Under the Basic Health Services Act, certain Medicaid eligible populations, e.g., the aged, blind, disabled, mentally retarded, chronically mentally ill or wards of the state are eligible to receive the basic Medicaid benefits and, long term care, home and community based services, medical care, and other institutional care which would not be subject to the prioritization process.

Part 1 Benefits/Health Partnership Act

Benefits under Part 1 of the employer based coverage must be at least equal to the minimum benefit package funded by the legislature for Medicaid recipients based on the priority scheme developed by the Health Services Commission.

Part 2 Benefits/Health Partnership Act

Benefits under Part 2 of the employer based health coverage will include dependent coverage and may also include a lower deductible, and more services options e.g., optical and dental care, as well as all coverage included in Part 1.

Although Part 2 deductibles and benefits are more generous than for Part 1, cost-sharing requirements for employees may be significantly higher.

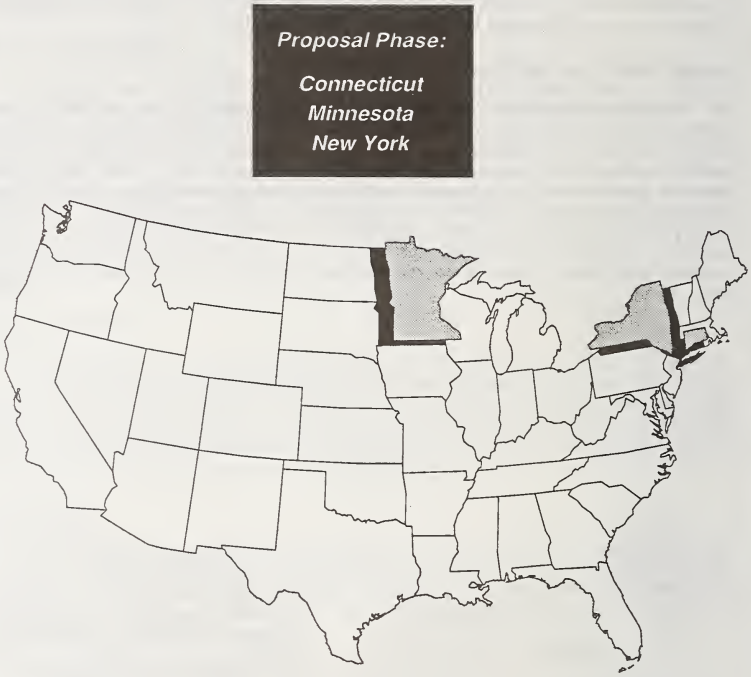
Liability Shield

The Basic Health Services Act provides a "liability shield" for providers by creating "a statutory distinction between actual medical malpractice, and not providing a service that society has determined not to fund." In other words, providers would still be liable for medical malpractice under current professional standards and tort liability, however, if a patient needs a service that is not currently funded by the benefit package, the physician could not be sued for not providing this service.

Mental Health Care and Chemical Dependency

The Health Services Commission has established a Subcommittee on Mental Health Care and Chemical Dependency to assist the Commission in determining priorities for mental health care and chemical dependency. Currently, these benefits are legally exempt from the prioritization process developed for funding decisions. However, a prioritized list of mental health and chemical dependency benefits is being developed to serve as a guide for the Insurance Pool Governing Board as it creates the employer based benefit packages mandated by the Health Partnership Act. In future years, the prioritized list of health services and the prioritized list of mental health and chemical dependency benefits may be merged, but this is not mandated at the present time.

Universal Health Care: Voices from The States
State Initiatives



CONNECTICUT

Summary:

In 1989 the Connecticut General Assembly established the Connecticut Blue Ribbon Commission on State Health Insurance under Special Act 89 57. The Commission was charged with developing a comprehensive and universal health insurance program for all persons in the state. The Commission worked with the Washington based consulting firm, Lewin/ICF in examining the problems of the uninsured and reviewing options for addressing this issue.

Although the members of the Commission unanimously endorsed the goal of available appropriate health care to all Connecticut residents regardless of their ability to pay, they were sharply divided on the specific form of long term strategy to achieve this objective. In the time frame provided, the Commission was unable to reach agreement on a plan that would fully achieve their desired goal. However, the Commission did unanimously endorse two actions which it believes will move the state of Connecticut toward the provision of available appropriate health care for all regardless of ability to pay.

The first action involves the adoption of seven separate, but integrated program initiatives that would expand health insurance access to approximately 61,000 uninsured persons at a cost of $24 million. The second action would require the legislature to establish a Health Care Access Commission to continue the work of the Blue Ribbon Commission. Senate Bill 342 reflects the Blue Ribbon Commission's recommendations.

Appendix C of the Blue Ribbon Commission Final Report contains a number of alternative proposals submitted to the Commission by various Commission members and interested citizen, provider and insurance organizations.

Program Initiatives

Medicaid Expansion

The Commission recommends extending Medicaid eligibility to children ages six to eight in families with incomes below 100 percent of poverty. The Commission also recommends aggressively implementing the presumptive eligibility provision for pregnant women. In addition, the state should expand the scope of its Model 2176 waiver which permits the state, through Medicaid, to provide community based benefits to disabled children and adults who would otherwise require institutionalized care and who would be Medicaid eligible only if institutionalized. Federal law allows 200 participants under this waiver, but Connecticut currently restricts the number to 50. The Commission recommends expanding waiver slots to accommodate the full 200 participants.

Medicaid Buy-Out

The Commission recommends forming a Medicaid buy-out arrangement in which Medicaid would pay an employee's premium share for some Medicaid eligible persons offered employment based insurance or for disabled or chronically ill persons eligible for COBRA following employment termination. The buy-out would be limited to cases where the cost of the premium would be less than the state share of the cost of providing Medicaid.

Subsidized Non-Group Products

The Commission endorses the creation of two subsidized non-group products aimed at filling the needs of two particularly vulnerable populations.

A plan with comprehensive benefits focusing on primary and preventive care should be made available to pregnant women below 250 percent of poverty and children in families below 200 percent of poverty. Cost sharing should be based on a sliding scale with a maximum of $500 for persons below poverty up to $5,000 for persons at 250 percent of poverty.

A subsidized non-group insurance product should be made available for low income disabled individuals. Any disabled person with one or more limitations in daily activity, with income between 100 and 200 percent of poverty, should be eligible. Premiums should be based on an income-related sliding scale so that 20 percent of the program costs could be paid through premiums.

Annual funding for both products should be limited to a fixed dollar amount. If enrollment exceeds the level of the appropriation, a waiting list should be established. Cost effectiveness in the provision of care should be emphasized in both insurance products. Among the cost containment features that should be considered by insurance carriers in designing the plans are a network of preferred providers, managed care, negotiated provider rates and high cost case management in which insurers demonstrate that providers have a plan for managing high cost cases.

Improvements in Access and Affordability of Private Insurance

The Commission endorses efforts to reform the private insurance market to provide greater access and affordability to small groups. The Commission recommends the following changes in insurance industry business practices in order to guarantee access and premium stability for health insurance for small groups:

- Insurers should be required to guarantee the availability of coverage to small groups.
- Insurers should be prohibited from using medical underwriting to exclude individuals from a group and should be required to reinsure high risk individuals through a newly created mechanism with premiums not to exceed 150 percent of the standard risk for individuals of the same age and sex.
- Costs for reinsuring high risk individuals should be met through assessments on premiums made by small businesses.

- Insurers should be prohibited from discontinuing an employer's health benefits except for such circumstances as non payment of premium.
- Premium revenues should be restricted by establishing limitations on the relative premiums that could be charged to new and established groups.

Creating Affordable Insurance Products for Small Employers Previously Not Insuring

The Commission recommends establishing a Blue Ribbon Insurance Policy on a three year experimental basis for small employers previously not offering coverage. This policy should:

- Provide a standard benefit package with state mandated benefits
- Set physician payment at 75 percent of the prevailing Medicare fee and prohibit balance billing for persons below 200 percent of poverty
- Limit loss ratios for firms based on the number of workers below 200 percent of poverty
- Waive the premium tax
- Prohibit medical underwriting

Direct Services Expansion

The Commission recommends expanding access to primary care services through funding a network of preferred providers capable of managing a patient's care with an emphasis on prevention and early treatment of conditions. Designated Community Health Centers (CHC) should provide comprehensive primary care services based on a sliding fee scale. The Commission proposes doubling the number of uninsured currently served by CHCs through an additional $4.3 million in state funds.

Reducing Hospital Uncompensated Care Costs

To determine the extent of the cost shifting, the Commission requested an analysis of the level and distribution of uncompensated care in Connecticut hospitals. In attempting to conduct this study Lewin/ICF discovered data collection problems that limited the accuracy of its findings. The Commission recommends that more accurate data collection on hospital charges and payments be required of the Connecticut State Commission on Hospitals and Health Care (CHHC).

The Commission also recommends that CHHC develop a plan to lower the approximately $20 million cost shift due to Medicaid shortfall.

Establishment of a Health Care Access Commission

The Blue Ribbon Commission recommends the establishment of the Health Care Access Commission including participation of the same groups represented on the Blue Ribbon Commission (health care consumers, community groups, large and small business, insurers, providers and state government), but that overall membership should be smaller.

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The group should monitor the implementation of program initiatives and evaluate their impact. Ultimately, this commission would be expected to develop a long term plan to achieve universal health care. The Commission would be required to submit an interim report in March 1991 and a final report in December 1992.

MINNESOTA

Summary:

In July 1989 legislation creating the Minnesota Health Care Access Commission took effect. The Commission's formal charge is to "Develop and recommend to the legislature a plan to provide access to health care for all state residents." A series of four communications committees and four program committees have been established to assist the Commission in its research activities and program design. A final report and implementation plan are due to the legislature by January 1, 1991.

In addition to the Commission, Minnesota has already successfully addressed the needs of many of their originally uninsured residents through a combination of Medicaid expansion; General Assistance Medical Care (GAMC), a state funded medical program for low income people; the Minnesota Comprehensive Health Association (MCHA), an insurance resource for those otherwise uninsurable, and the Children's Health Plan for children under 185 percent of poverty.

Also pertinent to a discussion of universal access initiatives is the introduction of a bill proposing a constitutional amendment guaranteeing all Minnesotans access to health insurance.

Health Care Access Commission (HCAC)

The 25 member HCAC includes fifteen members appointed by the Governor, three by the Senate, three by the house of Representatives, and four who are the Commissioners of health, human services, employee relations and commerce. The fifteen members appointed by the Governor represent a variety of backgrounds including consumers, business, labor, seniors, providers, insurers, HMO's and health benefits experts. Five people staff the Commission.

The four communications committees -- constituency liaison, public hearings, business and health care providers -- will undertake a variety of activities to obtain comments, suggestions and criticisms about the Commission's activities.

The four program committees -- demographics, delivery mechanisms, legal and finance -- are charged with monitoring the Commission's research activities and developing program recommendations.

- Demographics Committee

  This committee will contract for two major surveys in order to "develop a system to estimate the total number of uninsured Minnesotans by age, sex, employment status, income level, geography and other relevant statistics." One survey will seek information from Minnesota households and the other from Minnesota employers. Both surveys will seek to establish the basic insurance characteristics of households and employers and to elicit attitudinal information about possible program design features.

- Delivery Mechanisms Committee

  This committee will address the broad issue of program design and will bring together the work of the other program committees to focus on program design issues. An actuarial and benefits design consultant will assist in the final stages of this process. The Delivery Mechanisms Committee has made three recommendations to the Commission regarding basic research and policy emphases. These have resulted in three Commission recommendations regarding further staff direction. The first instructs the staff to direct their research towards a system of universal participation while exploring the issue of mandatory versus voluntary insurance. The second recommends that program designs which support the employers' current role in providing health insurance be emphasized. The third Commission recommendation recommends that those program designs that permit participation by people who do not qualify for a subsidy be emphasized, (provided these participants pay the full, unsubsidized costs).

- Legal Committee

  The Legal Committee has two primary charges: (1) to conduct an expert and thorough analysis of ERISA and its effects on the range of options open to states regarding health benefits and (2) to make recommendations concerning changes in Minnesota state law that would assist the Commission in its efforts.

- Finance Committee

  This committee will conduct financial analyses, including estimates of costs, revenues and the means by which additional funds can be raised.

Minnesota Program Initiatives

Medicaid Expansion

The income ceilings for Medical Assistance in Minnesota are at, or just below, the maximum allowed by federal statute. Eligible populations include:

- Families with children whose incomes are at or below 133 percent of the AFDC grant amounts.
- Pregnant women and children up to age one whose incomes are at or below 185 percent of the poverty level.
- Children under age 21 in families meeting the income and resource requirement of the AFDC program.
- Children up to age eight in families with incomes at or below 100 percent of the poverty level (no resource standard).

- Other persons whose incomes are at or below 115 percent of the poverty level including the blind, aged or disabled.
- In July, 1990, the income ceiling for the blind, aged, disabled and will be raised to 120 percent of the AFDC grant amount.

General Assistance Medical Care (GAMC)

This program provides health care to people who receive General Assistance, but are not categorically eligible for Medicaid. These are primarily young, single adults, many of whom are mentally ill or chemically dependent. Cost is shared by the state and counties and benefits are comprehensive.

Minnesota Comprehensive Health Association (MCHA)

MCHA, established in 1976, provides otherwise uninsurable persons an opportunity to purchase health insurance. Rates are set according to gender and age and premiums cannot exceed 125 percent of the average cost of individual policies. All insurers are required to participate in MCHA. When claims exceed premiums (as they have every year since 1979) deficits are shared on a pro-rated basis.

Children's Health Plan (CHP)

In 1988 Minnesota established the Children's Health Plan to provide primary and preventive care for children whose families have incomes at or below 185 percent of the poverty level. CHP does not cover inpatient care or mental health benefits, but outpatient care is comprehensive including physician care, diagnostic screening, preventive services, dental care, rehabilitation therapy, medical supplies, laboratory use, x-ray, vision care and eyeglasses, immunizations, most prescription drugs and home care services. The Children's Health Plan is funded by general revenues and a $25 annual premium for each child. Several social, community and health agencies have chosen to pay the premiums for the children they serve. The Minnesota legislature appropriated $10 million in 1990-91 for the Children's Health Fund.

The 1990 Minnesota legislative session entertained a proposal to expand the Children's Health Plan by adding all uninsured pregnant women for prenatal care and all uninsured children up to age 18 regardless of family income. Agreement was not reached in conference committee and current levels of spending and accessibility have been maintained.

NEW YORK

Summary:

In his 1989 State of the State address, Governor Cuomo directed the Commissioner of Health, Dr. David Axelrod, to develop a proposal to address the needs of New York's growing numbers of uninsured and the rapidly rising cost of health care. UNY*Care, Universal New York Health Care, was developed in response to the Governor's directive. The Department of Health submitted the proposal to the Governor and has been directed to continue work on UNY*Care and to continue meeting with all interested parties in the development and refinement of the proposal.

UNY*Care would be a system of stable and affordable health care for all New Yorkers. It would combine cost control and expanded tax-based programs and private insurance. UNY*Care's design rests on two basic principles: 1) universal coverage can only practically be afforded by accepting and strengthening the system of private, employer-based insurance and by expanding public programs for those not in the work force, and 2) this incremental improvement must be linked to a fundamental reform of the payment system with all providers facing a single payer, and with all residents being assured access to a sufficient level of care.

As a first step toward universal health care, the Governor introduced legislation in January 1990 to create a subsidized health insurance program for low-income children that would include incentives for employers to provide insurance for the children of their employers. In addition, New York State will be conducting a pilot program in a multi-county region of the state to reform the billing and payment system, a key element of the single payer concept.

Universal New York Health Care

UNY*Care, a combination of employer-based and public-sponsored coverage, would extend preventive care to all residents from birth to 17, regardless of income, and would strengthen primary care programs for all low-income people (those with incomes below 200 percent of the federal poverty level). Catastrophic acute care benefits would be extended to all New Yorkers. The 14 percent of the population who have no coverage at all would be protected, either through tax-supported or employer-based coverage. More specifically, UNY*Care would provide for the following:

A Uniform Billing System

A single-payer authority ultimately would be deployed between third-party payers and providers. Providers would be guaranteed payment for covered services and would no longer face multiple billing procedures, requirements and incentives. The payer authority (or its agent) would bill appropriate third party payers for each patient; providers would interact with one payer thus reducing administrative and billing costs and avoiding burdensome coordination of benefits issues. Shifting to a responsive, less inflation-prone system would require a major overhaul of our billing and payment

system. A regional demonstration project would be carried out to prove the feasibility of creating an integrated electronic claims processing system that would operate much more efficiently than our current one, achieving the rapid payment and other economies of a single payer system.

A Universal Enrollment Card

All New York residents would be issued a single enrollment card establishing membership in the UNY*Care system. Each resident would be treated alike in terms of service delivery and billing. Covered services would be provided to the patient, with the provider billing the payer authority, who would pay the provider and recoup any due copayment from the consumer. UNY*Care would eliminate discrimination based on payer; services would be delivered based on medical need.

A Single Rate-Setting and Reimbursement System

After the creation of an integrated billing and payment system, the next step would be to move to a single payer authority, acting as a rate-setter and negotiator, determining uniform rates of reimbursement for all providers. Through this authority state government would be permitted to act as a purchaser and buyer of medical care rather than one of many agents who pay for it, a crucial system change if costs are to be brought under control and coverage made universal.

Subsidized Insurance Coverage for the Poor and Near Poor And Preventive Care for Children

UNY*Care would provide public coverage for all persons with incomes at or below 100 percent of the federal poverty level, would subsidize coverage for all persons with income between 100 and 200 percent of the federal poverty level and would provide access to preventive care for all children 0 through 17 years of age, regardless of income.

Standard Benefit Package

The standard benefit package would likely include routine physician visits, physical and occupational therapy, laboratory and diagnostic services, inpatient and catastrophic care. While this coverage would specify a minimum , it would be sufficiently high to encourage acceptance by all parties as the basic standard of care.

Catastrophic Acute Care Coverage

The responsibility of private insurance to cover health care costs would be limited to a basic annual amount, roughly $25,000 each for inpatient and major medical care. The state would cover catastrophic medical expenses beyond the $25,000 minimum.

Coordinated System Growth

UNY*Care would permit the development of a health care "budget" detailing all projected cost increases and expected revenues from all sources of payment on an annual basis. Such a budget would permit elected officials, affected groups, the public, and UNY*Care administrators to plan for needed system growth, including increases in reimbursement, premiums, and new state revenues.

Financing

In financing expanded coverage, a fact often ignored is that new costs to society can be limited by restructuring the use of certain resources already available. UNY*Care proposes to convert to insurance coverage the present expenditure of $1.1 billion in bad debt and charity care funds, and also to utilize a portion of the nearly $4.5 billion annual increase in medical care inflation currently paid to providers to fund the costs of universal coverage. UNY*Care would also ensure that care is delivered more efficiently and that the responsibility for paying for health care be equitably shared. Employers who do not pay for coverage now would start doing so and would receive a subsidy to help them. People who could pay something but do not, would start. State government would pay for those who could not and would raise the money equitably through tax levies.

The overall net financial impact on society for expanding coverage would also be limited because the people of New York State already are paying, in large part, for the sick care of the inadequately insured. Their lack of insurance does not keep them from becoming ill and seeking services. But, the way their care is financed is inequitable and the way their care is delivered is inefficient, problems that UNY*Care would address.

Chairman STARK. If I could follow up on your UNY Care proposal, there is a famous commentator on the state of medical care delivery in the country, who shall remain anonymous, but who, in speech after speech, has suggested he was not sure where he got this figure, but he has used it carelessly and recklessly for the last number of years.

If we did in fact have a single payer system in this country, such as the one you outline, it has been suggested, and I want to see if you think this would apply to New York, that hospitals would be able to reduce their staffs by one employee per bed.

I had a hospital suggest maybe a half an employee per bed, but if that figure is right, you are talking a million employees, and if you say—I don't know where, except in Hawaii, anyone would be willing to work for $20,000 a year, including benefits, but that would provide the $20 billion Mr. Gradison is looking for to cover the uninsured.

I think you are right in terms of whether you can pull it off in New York as being a political problem. I have long thought we all carry plastic cards around for one reason or another. There is no reason some kind of single payment system shouldn't save us a lot of money.

Mr. BEAUCHAMP. I am not going to do my own sums to match that famous person who is probably an economist.

Chairman STARK. I think he is a Congressman.

Mr. BEAUCHAMP. Maybe in my—

Chairman STARK. One of the more modest ones, I might add.

Mr. BEAUCHAMP. That—I would say that we believe that we can close the gap between the United States and Canada. We are roughly 10, 13 percent higher. They take 10 percent of their total cost for administration, and we are around 20, 23 percent.

We think a realistic figure would be around 15 percent. I don't think we can achiever the efficiencies of a purely tax-based system, but I think we can save 7 or 8 percent of the cost, modest—that adds up to around $2 billion in New York State. That is an impressive saving.

Chairman STARK. Thank you.

If only you four gentlemen were representing Alabama, Mississippi, Arkansas, and South Carolina, our problems would be over, but the fact is you are not, and we have all heard your testimony. We are all jealous of what Hawaii has done.

You have all talked about a Federal-State partnership. We are kind of casting about as a committee, really not necessarily looking to expand the bureaucracy or our own jurisdiction, but suggesting sooner or later, that somebody is going to move to cover the people who are uninsured, or make more fair the way we pay for medical care.

What do each of you think the Federal role ought to be? Should we provide reinsurance, in effect take the high-risk, long-tail stuff? Should we just set Federal standards and give you a number of years to catch up with it and then provide a bill if you don't?

Can each one of you pick the one area you think we ought to get going on first or concentrate our efforts in? Do you want to lead off, Dr. Lewin?

Dr. LEWIN. Sure. Thank you.

I personally believe that we ought—Federal role ought to be to come up with a national health plan with minimum benefits that would be afforded to all citizens, as a first step. And then, of course, that would be age-specific, and I believe—and then allow work with States to implement that kind of plan locally.

We are approaching $600 billion a year of Federal health care costs, and if we look at the—that amount of money, I don't—we know as a Nation we don't need to spend more money, we need to somehow convert the system.

How to convert the system: I think that plan would be a good step in the right direction. Allowing innovation on the State level with Medicaid and Medicare would be at least, in my view, in Hawaii, is our next step. We have got the universal access type of thing now.

We would like to change the health delivery models and look at alternate ways of delivering the care to people, get the employers and the unions involved to be able to help choose more efficient ways to proceed.

I also believe as a leader in public health that we need to fund the National Health Objectives Act, which has been sitting around now—the Senate—to put some money into prevention. We have got to put a little bit of seed money.

We are actually talking $1 per citizen. That would be $300 billion or so, $1.25. The directors of health of all States have asked Congress to look at it. There is a measly amount of money for prevention and health promotion.

We think States could implement the year 2000 objectives with a little bit of seed money. I think the Federal standards allowing for innovation with the existing programs, we might deal with what we have got and do quite well.

Chairman STARK. I might point out that two of your colleagues here, at one point, had Medicare waivers, and found that innovation didn't always work. So that has been tried in the past with varying results.

But when you say Federal plan, I have proposed one for discussion purposes. Let's take Medicare, for example, it is low payments for some providers, and it is loaded with bureaucracy, but it is a plan and you know what it is, you know what the benefits are, what it covers and doesn't cover, what hospitals get and what the doctors get.

Are you suggesting that we set a Federal minimum? Then you could go ahead and supplement it any way you want, pay for it any way you want, and if a State doesn't implement the plan, we would have to go in and impose it.

Dr. LEWIN. I think it is really lacking in the primary care-prevention. The State health insurance program, the annual policy is costing about $500 a year.

Chairman STARK. Would you rather have us provide the primary care at the Federal level, and let you guys worry about the high risk, or would you rather have us do something like Medicare where you fill in the primary care and the copayments?

Dr. LEWIN. I think the catastrophic and the super-expensive end, it would be necessary for the Federal Government to stay involved in that, but I believe adding for very small cost, allowing the inno-

vation to go to give the senior citizen in Medicare, for example, an annual health assessment, maybe an internist physical.

I don't think an internist physical is the way to maintain health, necessary. We have to look at what kind of annual assessment is necessary to maintain health and assure people don't use the hospitals to a higher degree than necessary.

But preventing hospitalization, preventing emergency room visits. One emergency room visit in Hawaii costs as much, on the average, as the entire health policy for the GAP group person for a year. That is absurd. We have to keep that person out of the emergency room.

Chairman STARK. My own county, the emergency room and hospital is all there is.

Mr. Hooley.

Mr. HOOLEY. I think a national plan would be very helpful to us in Massachusetts. I think the plan should include basic benefit package. And also what we are doing in Massachusetts is basically extending the present insurance system of public and private insurance to the last 10 percent of our population that has no insurance.

So, we think the employer mandate is essential if you are going to go that route. Otherwise, some of the experience so far with other States where they have done incentives to provide insurance to the uninsured, especially in the workplace, have been slow to catch on.

So, we think that that would be extremely helpful to us in Massachusetts is those two things took place.

Chairman STARK. You want me to take the political heat in an election year for mandates?

Mr. HOOLEY. Basically, we have taken it in Massachusetts. In fact, the—well, I don't—I am not commenting in your own situation. I think that the mandate issue is a tough one, and we struggle with it in Massachusetts. It is controversial in one sense, but we have had some experience with it, and what we find is that most of our businesses in our State are already providing insurance for their workers, and the question of insurance reform and insurance cost is balanced with the mandate.

Some businesses believe that, in fact, if they get relief in those two other areas, the mandate will be worthwhile. Also, there is growing knowledge that in fact, the way that we fund uncompensated care for workers is by taxing companies that provide insurance for their workers already, so it is kind of a double hit, and the issue of fairness is something that we certainly are concerned about.

But I think that is—and also, we think that—we think those two things would really be helpful. We in Massachusetts have taken advantage of some of the Federal expansion of Medicaid, and so, we are up to our limit, and that is one of the reasons we have a low percentage of people who are uninsured, because we have expanded our Medicaid program to a great extent, and for good purpose, such as we have been doing since 1984, providing benefits to pregnant women under 200 percent poverty.

And we feel that has been a worthwhile investment. The same with people who are receiving AFDC or Medicaid, allowing them to

basically go to work, and we would supplement or provide them with health benefits up to 2 years.

We have had 9,000 people go off of welfare, and we have seen plenty of evidence that not having health insurance has absolutely been a barrier for people going into the workplace.

So, some of the things we have done around, using Medicaid and supplementing that, I think, have been very effective.

Chairman STARK. Dr. Crittenden, what would you say for the State of Washington?

Dr. CRITTENDEN. I look at this as a State-Federal role, and I see the States as probably being the good locus for managing the pieces, where you can decide on the local variations, where you are going to put what MRI's you do get. I think on the Federal level, you have to have active participation.

At the minimum, it needs to have some basic principles. You need to have some priorities. And there also has to be some involvement in financing the system. I think the States alone absolutely cannot finance this whole health care system.

I think the areas you can get involved in are equitable financing or setting up a financing system that equitably taxes and equitably distributes that. I think there is an issue with the benefits, we need to make sure people are getting a minimum set of benefits. The issue of portability, going from one place to another, moving, which is one of the gaps people run into.

Those are the main issues.

Chairman STARK. Thank you.

Dr. Beauchamp.

Mr. BEAUCHAMP. Yes, sir. I think that if you think about this problem in sort of two phases, the first thing that should happen is the State should be specifically challenged and offered incentives to innovate. There ought to be a way in which Congress could reflect upon ERISA, and States could be challenged by Congress to in fact step out with an expansion of the employment-based insurance system.

The difficulty with that idea is any State that does take up the challenge runs the risk that, to a certain extent, has dogged Massachusetts. It is perceived as an antibusiness State. So the Federal Government must help soften the costs to businesses who would be required to carry insurance.

If surrounding States don't also move out, innovation can be very difficult politically, so that the short-run policy, I think, has to change very quickly to a national strategy that decides once and for all whether we are going to use employment-based insurance or something else like Medicare and use that as the platform, as Mr. Stark suggested, for dealing with the uninsured. We have found that the small business opposition to proposals like our own is the fundamental obstacle to moving ahead.

I think there were some interesting ideas about who would share responsibility. I don't tend to see this issue as either a Federal or a State one, as other people have suggested. I think we ought to work on who shares what responsibility. And it seems to me that the Federal Government has to deal with the problem of the South, where I spent most of my life, still a very poor region of the United States: The South would have great difficulty moving forward with-

out major Federal assistance, and I think a basic reform to the Medicaid program is a key to that problem and to getting universal coverage.

Also, catastrophic and acute care costs seems to me probably are more easily borne by the Federal Government. Primary and preventive care, along the lines that Hawaii is adopting, is something the States ought to be responsible for more directly and maybe even bearing the major costs of that basic reform.

The integration of the system cost controls, and management of the system, perhaps along the lines I suggested with UNY Care, seems to be a central role for the States, with Federal guidelines. The States are where insurance reform is properly tackled.

Chairman STARK. Thank you all.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

It strikes me, Mr. Chairman, as curious, after the 25-year period of our not doing anything new in Washington in the health care field, the last major steps were 25 years ago in 1965 with Medicare and Medicaid, there is this breathless waiting for the Federal Government to make some decisions and set up a structure.

I think the representatives of these States are to be congratulated for feeling that if they want to do something with health care problems, they better not wait on us. I hope we don't have to wait another 25 years to recognize we are in a stalemate down here.

Something needs to be done, no argument about that, but there doesn't seem to be the ability to work it out, in view of the reality that a number of groups in effect have a practical veto power over some of the actions that have been discussed, including the taxpayers, because of the heavy costs that are involved.

Dr. Lewin, what has been the actual impact in Hawaii on small business? We hear a lot of concern on that expressed elsewhere. How has it worked out?

Dr. LEWIN. Small business has the same complaints as any other State, in terms of doing business, principally because of real estate values and rents and so forth are very high in Hawaii. Cost of business is high.

But in 1982 when the ERISA law was challenged by Standard Oil, the ERISA notion that ERISA was supreme, and the State of Hawaii had no right to provide this mandate, every employer in the State had the option during the year that the Hawaii prepaid health plan was vacated to leave the program, abandon it, and in fact no one did except Standard Oil.

The program continued on, and small business in Hawaii pays the lowest insurance rates in the Nation because of the current rating system for all small businesses.

I hate to see the insurance industry within—in fact, the commercial insurers for health fled Hawaii. They are there for life insurance and all other kinds of insurance, but the commercial insurance fled naturally when we implemented prepaid health care, and in doing so small business now enjoys the lowest rates for health insurance, the same as the big companies pay.

Mr. GRADISON. Why did they flee?

Dr. LEWIN. They fled because when we put the whole gap group in, everyone, all employees down to even one employee of a busi-

ness, we didn't exempt. If we exempted, say, a business of six or less, we would have 30 percent of our work force out of the insurance, health insurance area, so what we did was put everybody in together, and the insurance companies went in to compete on that group.

They know what the actuarial ratings are for them and the rates went down as low as they are for any big business. So therefore with that caveat, Hawaii's small business has done very, very well. That is not saying they are happy with the cost of health insurance, but it is still the lowest rates in the Nation, by far.

Mr. GRADISON. Nobody is happy with the cost.

Dr. LEWIN. Nobody is happy with it, but it is half the cost of what you would be paying in California for small business, or anywhere else in the country.

Chairman STARK. Will the gentleman yield?

Mr. GRADISON. Of course.

Chairman STARK. Is there an average cost for individuals of small businesses?

Dr. LEWIN. Ninety dollars a month is the current rate small business pays for full Blue Cross, Blue Shield in vitro fertilization included, mental health benefits.

Chairman STARK. What is the maximum out of pocket?

Dr. LEWIN. It is a 60/40 split, so it would be about, the employer, the employee would be paying.

Chairman STARK. I mean copays?

Dr. LEWIN. There is no copay.

Chairman STARK. And catastrophic?

Dr. LEWIN. If you choose a managed care program, there is no copay. If you choose Blue Cross, you pay usually 20 percent of physician's fee and hospital cost. If you choose one of the many manager care programs available, there is no copay.

Chairman STARK. Thank you very much.

Thank you.

Mr. GRADISON. Thank you, Dr. Lewin.

Dr. Crittenden, I wanted you to know how pleased a number of us were to have a chance to meet here just a few weeks ago with Governor Gardner and the other governors who are going to be involved in the project at the level of the National Governors' Association, and try to think through what they may wish to recommend.

We are very happy to have Governor Gardner's leadership, along with Governor McKernan of Maine, and in that effort, certainly it is my hope they will suggest whatever they want to suggest, but I do hope—and I am mentioned this in hopes you can carry a message—I do hope they will include in their recommendations a candid assessment of what they think we might be able to do in Washington to help the States accomplish what the States want to accomplish. That has been mentioned here in various forms.

That may not be the solution to the problem, and I recognize that some people that Mr. Stark and I work with here in Washington may not want to grant waivers because they may feel encouraging State action is a barrier to Federal action. And that is a problem we worry about all the time.

But I really am encouraged by this morning's discussion which gets down to some of the specific things we can do to get out of your way or remove hurdles or barriers to you doing what you want to do, not what we are forcing you to do.

Dr. CRITTENDEN. I appreciate that. The governors are looking very closely at that issue and they will include in their report, I am sure, within the next 6 months, being very specific about those issues.

Mr. GRADISON. Did I understand correctly their target date is next February?

Dr. CRITTENDEN. Some principles will be discussed next month, actually, at the summer meeting. I think before we have any real policy, which has to be decided by two-thirds vote, it will be at least until January or February when we have the winter meeting.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Each of you referred to some kind of standard package. New York called it standard package. Washington, basic health plan. Would you describe what those packages cover and what they don't?

Dr. LEWIN. The Hawaii Prepaid Health Care Act, the employer-mandated program is the standard package anybody gets in any State with Blue Cross or Blue Shield. You can also buy it through Kaiser Permanente.

Blue Cross or Blue Shield or managed care version that Minnesota would have or Kaiser Permanente would have without the copay side. Comprehensive outpatient, emergency room, hospital services usually up to 120 days, annual coverage of hospital, including elective surgery. That is the typical comprehensive package. That is what 88 percent of our people have through prepaid health care.

Medicaid offers a very similar coverage package. The SHIP program is the one that is different, which addresses the gap group that remains. Those are the unemployed students, owners of small business, because they don't have to insure themselves, only their employees, and a few other people here and there, part-time employees.

Those people have a basic benefit package which has more primary care and prevention services. It has emergency room with a deductible with $25 per visit, and it has 5 days in patient care, and then the benefits cease. And the reason for that is because the gap group is currently getting its care in hospitals and emergency rooms as uncompensated care and we are all paying or it through our insurance rates.

Mrs. JOHNSON. Its primary difference there is in providing coverage for ordinary office care, ordinary preventive care, and the only limit is really the hospital?

Dr. LEWIN. In some ways it is better than what the standard Blue Cross plan has. An adult can go in for an annual assessment, can get cardiac stress test. A woman can get mammograms and Pap smears. Children get all immunizations covered. All the preventive stuff is in that package.

We are trying to make a gesture to insurance and industry and say these are the basic things that should be covered first, and

then let's look at the catastrophic side and see what needs to be covered.

Mrs. JOHNSON. Basically one can think of the Hawaii plan as Blue Cross, Blue Shield or Kaiser Permanente?

Dr. LEWIN. Yes. If this gap program didn't have some attenuated benefits, the dependents of the employee would try to migrate over to the State health insurance program since it is cheaper. We have had to make sure they don't want to do that. That is why we cut the hospital benefit side of it back.

Mrs. JOHNSON. OK.

Dr. CRITTENDEN. Basically our health plan is somewhat similar. Ours is the basic package for health insurance plus more preventive intervention. It is very similar. We have group health co-op in Seattle and throughout the State which is similar to Kaiser, and they are one of our main contractors with the basic health plan.

They do cover all the preventive things, I think, with a minimal copay. So we tend to emphasize all prenatal care, well-child care.

Mrs. JOHNSON. Is there any limit on hospitalization or surgical options?

Dr. CRITTENDEN. Basic health plan, no. We discussed that. We did toy with the idea what Hawaii ended up with. We didn't do that for a number of reasons. The cost of the plan is a little bit more in our case, probably because of that hospital component.

Mrs. JOHNSON. I see.

Chairman STARK. What does yours cost, if I may interrupt?

Dr. CRITTENDEN. Roughly about $80 per month per person.

Chairman STARK. Hawaii's is $90.

Dr. LEWIN. Our SHIP is $50 for adults and $20 for kids, per month.

Chairman STARK. Wow.

Mrs. JOHNSON. Yes.

Mr. BEAUCHAMP. We approached the problem somewhat differently. We were trying to change the whole structure of insurance and payment, so what we needed more than anything was a number to use for estimating purposes throughout the whole system, and we had to communicate to people what level of coverage we intended, rather than specific details.

We were afraid if we listed specifically what we wanted, we would never get out of the starting blocks, so we went to the level of coverage that can be found, say at State employees' Blue Cross plan, and we talked to actuaries in and outside of Government and determined a dollar figure that represented what we felt like was generous coverage in New York State. That would be around $2,800 for a family coverage in the State, and around $1,200 for individual coverage.

So we didn't try to list the schedule of benefits, but we think it would be very comparable to what the gentlemen have been talking about.

Mrs. JOHNSON. Also, does it allow more competition by creating various packages with various price levels?

Mr. BEAUCHAMP. In our proposal, we don't have specific discussion. In our next revision, we tend to offer as a basic feature of our proposal, the choice and economically rewarded choice to go to managed care versus standard arrangements, and we hope that

through the incentive of the single payer we can encourage more people to select manage care and hopefully close panel kinds of arrangements.

Mr. HOOLEY. Our law basically requires us to include all of our mandated benefits in any insurance programs that we offer.

We are, though there is a lot of discussion in Massachusetts, as there are across the country as to whether or not small business in particular should be allowed to buy insurance that has less benefits. We are looking at that. We haven't really concluded—we haven't come to any conclusions on that, and our first round of phase and initiatives we have basically offered, we have four manager care programs, HMOs and one PPO, because the law also encourages us to offer that as an option.

But we now are reviewing a second set of proposals that insurance companies have submitted to us that are more basic coverage, an indemnity product with some copayments and deductibles in them that would be more affordable. So, in fact, our basic plan is really related to costs more than benefits.

Mrs. JOHNSON. You mentioned in your testimony that your goal is to provide health insurance worth $1,680?

Mr. HOOLEY. Right.

Mrs. JOHNSON. I hear your proposal is similar to New York's?

Mr. HOOLEY. Right.

Mrs. JOHNSON. Not unlike our struggle in Congress to identify that amount of health care value that we would tax subsidize?

Mr. HOOLEY. That is right.

Mrs. JOHNSON. So you define the level rather than the components. In an earlier discussion, had you mentioned something about a $2,000 deductible?

Mr. HOOLEY. We were actually—we have a program that is going in effect this summer for unemployed workers, and we have a hospital deductible. It is not $2,000; it is around $1,000, but the benefit packages pays for prenatal care and doctor's office visits.

It tries to do what Hawaii has done to push people away from the hospital setting, but also then while they have lost their job, if they can't afford a COBRA option, would give them basic protection during that window when they are looking for another job.

Mrs. JOHNSON. It is non-COBRA eligible, that particular piece the program has focused on?

Mr. HOOLEY. Yes.

Mrs. JOHNSON. Thank you very much. That is very helpful to hear exactly what you are talking about when you talk about the health care packages. One of the difficulties that we have faced—and I am interested that you used a dollar cap—is that I would have problems offering Hawaii what they want. A lot of our employers have gone around State mandates through ERISA in order to provide something that is affordable and comprehensive. If we give you exemption under ERISA, what you really would have then is the right to mandate on to the ERISA-covered population. From the rest of the Nation's point of view, at least from my point of view, as a Connecticut legislator, I wouldn't want to do that, because our mandates have excluded people from of health care, not included them. If it weren't for ERISA, we would have more problems than we are facing.

I have two comments and then you make any comments you want on my comments or anything else.

I really hear your repeated interest in latitude to innovate, but we need help on that because it is hard for us to provide latitude, so you need to think over a period of time where the latitude is, where you need latitude, and where to find it, so we have better guidance on the latitude issue.

Second, a number of you have mentioned a need for insurance pools, and in my experience it is that pooling of risk in the small group market that creates premium stability and makes low premiums possible. Right now we don't have that capability. We don't provide it federally, nor do all States. So I wanted to mentioned that. That is something we really need to address.

Then on the administrative costs, the single paper issue you are doing in New York interests me as much as it does the chairman, although I don't entirely agree with him.

I realize the private sector approach, which is what you are primarily dealing with, has imposed some complexities on employers that is very costly. On the other hand, those private sector people don't send papers that say this is not a bill, so there are ways in which Medicare's administration is much more costly than the private sector's administration.

While they have managed care oversight, they don't have the degree of administrative investment in oversight and the PRO's that Medicare has. They don't have some of the denial problems and massive churning of reimbursements that our hospitals are experiencing for HCFA's requirement, for example, that the bill be entirely in the same ink.

I wonder how your experience in cost reduction or in simplifying your system would work if you included Medicare and what you would want us to do to Medicare to make it encompassable in your single-payer system.

You don't have to answer that now, but that is where my thinking is going. Your thoughts would be much appreciated in the future.

[No further information was received.]

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I want to thank the panel and I hope that you will continue to keep us informed. The ideas that you are able to bring to reality are things we are struggling with all the time, so each of you in a little bit different way are putting together things that we would like to encourage.

I should say, I hope the States would get this all done in the next year or two and simplify the committee's work, but I rather don't think that is going to happen. I do intend to spend more time in Hawaii finding out what is going on over there.

Thank you all. I appreciate the effort of you coming to us, and we will look forward to seeing you in the future.

The committee is adjourned.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

GEORGETOWN UNIVERSITY MEDICAL CENTER

Georgetown University Children's Medical Center

July 1, 1990

Mr. Robert Leonard
Chief Counsel
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20512

Dear Mr. Leonard:

I am writing you in my capacity as president of the American Society of Pediatric Nephrology, in support of the legislation on "medicare buy in". The American Society of Pediatric Nephrology is the national organization of the 360 doctors who are specialized to take care of infants, children, and adolescents (up to 21 years of age) with kidney disease in the United States.

In 1987, the prevalence of end-stage renal disease (ESRD) in children (0-14 years) was 1,992; the incidence was 429 per million population adjusted to the age, sex, and race distribution of the U. S. population, 1980. We recently surveyed 15 centers involved in the care of children with ESRD (June, 1990). Of about 900 pediatric ESRD patients receiving renal replacement therapy in 1989, 25% were not covered by Medicare. There are at least four groups of pediatric patients who are not currently eligible for Medicare entitlement: (1) children of young (teen-age) unwed mothers who are receiving public assistance; (2) children of non-working single parents who have not contributed to the Social Security System; (3) alien children or children of undocumented aliens who are residing permanently in the U. S.; and (4) non qualifying intact families. We are currently trying to determine the incidence of each of these groups. There are also some impediments to Medicare eligibility. These include: (1) inability to traverse the Medicare bureaucracy; (2) inability to afford Medicare co-payment; (3) inadequate private insurance; and (4) inadequate coverage by a pre-paid health care agency.

For the reasons enumerated above, the American Society of Pediatric Nephrology requests that pediatric patients be specifically included in any "medicare buy in" system.

Sincerely yours,

Pedro A. Jose

Pedro A. Jose, M.D., Ph.D.
Vice-Chairman, Department of Pediatrics
Director, Pediatric Nephrology
Professor of Pediatrics and Physiology and Biophysics
President, American Society of Pediatric Nephrology

3800 Reservoir Road NW Washington DC 20007-2197

STATEMENT OF MARTHA McSTEEN, PRESIDENT, THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman, I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. We appreciate your holding these hearings to explore expansion of Medicare to groups not currently covered by health insurance. Although the hearing announcement referred primarily to groups other than the elderly and disabled, I'm sure you realize there are coverage and cost barriers which effectively deny Medicare access to up to half a million seniors and disabled individuals. That is why we urge the Subcommittee to consider our small but important Medicare Access Proposal to (1) cap lifetime Medicare Part A premium payments to a maximum of ten years; (2) limit Medicare Part B premium penalties; and (3) provide Medicare coverage for 65-year-old spouses of younger fully insured workers.

Cap Lifetime Part A Premiums.

Purchasers of Medicare Part A Hospital Insurance can unfairly end up paying as much as 300% more for this coverage than both the average worker and his or her employer paying into the trust fund through payroll taxes. Alyce Morsman from Hibbing, Minnesota, is a case in point. Ms. Morsman worked as a school teacher all her life. She began purchasing Medicare Part A coverage in 1973. By the end of 1989, Ms. Morsman had paid a total of $22,026 in Part A premiums.

On the other hand, an average earner working in a Social Security-covered-job has paid only $3,074 in payroll taxes from the beginning of Medicare in 1966 through 1989. Even when you add the employer's contribution, the total is still only $6,148--less than a third of what Ms. Morsman paid for the same coverage.

Ironically, had Ms. Morsman been born just one year earlier, she would have been extended coverage automatically when Medicare was enacted. Her contemporaries were only required to have one and one half years of Social Security credits to qualify for Medicare.

One possible legislative solution would be to limit the number of Part A purchase years to the number of work years required by a senior's comtemporaries to qualify for Medicare. However, a less costly alternative would be to limit lifetime Part A premiums to ten years--the number of years that people born after 1929 are required to contribute in order to be eligible for Social Security and Medicare. **The National Committee recommends that seniors be assured that once Medicare Part A has been purchased for ten years, premiums would be eliminated.**

Currently, about half a million seniors are ineligible for Medicare because they, or their spouses, taught school, worked with religious organizations or for some other public or non-profit organization not covered by Social Security. Yet only 20,000 of these seniors purchase Medicare. One of the reasons is cost. Even though the monthly premiums were reduced from $234 a month in 1988 to $156 in 1989 and to $175 this year, that is still a considerable cost to many seniors.

It is anticipated that the budget impact would be reduced in future years, because, thanks to changes in the law, fewer seniors are expected to be left out of the system. For example, Federal employees were brought under Medicare effective January, 1983; non-profit organizations were brought under Social Security and Medicare in January, 1984, and new state and local employees were brought under Medicare in April, 1986. Therefore, it is only the current senior population which is most vulnerable and who should be encouraged to seek coverage through affordable purchase.

Limit Part B Premium Penalties.

Another barrier to Medicare coverage is the unlimited premium penalty for late enrollment in Part B. The law requires a Medicare beneficiary pay a 10% surcharge, or penalty, for every year he or she delays Part B enrollment after turning 65. Congress originally set the 10% surcharge to discourage eligible seniors from delaying enrollment until they anticipated significant health costs. Although the actual cost to Medicare has never been analyzed, the true cost of each year of delayed enrollment is not likely to be as high as 10%.

A total of 1,018,200 beneficiaries paid Part B monthly premium penalties in 1989--of which 603,493 paid more than 10%. The penalties go as high as 210% for a monthly premium of almost $86. **The National Committee proposes that penalties for Part B be capped** at 10% as proposed in legislation introduced by Congressman Barney Frank. A similar limit has already been placed on Part A premiums. We estimate that capping premium penalties at 10% would cost about $81.4 million a year.

At the same time, **late enrollment penalties should be removed when enrollees have been penalized for twice the length of time enrollment was delayed**. For example, someone who waited 4 years to enroll would pay a 10% penalty for 8 years. If such a time limit was imposed, we estimate that about 603,500 beneficiaries would no longer pay the penalty. The additional cost to Medicare would be about $22.7 million a year.

Many seniors are paying penalties without fault of their own. In 1982, a law was passed requiring employers to offer the same insurance to Medicare eligible workers as they offer younger employees. Seniors who choose the work-related health insurance protection and therefore do not enroll in Medicare Part B at age 65 are granted a special late enrollment period without penalty until their work-related coverage ends.

However, the 1982 provision is not retroactive. Workers who postponed Part B enrollment prior to 1983 because they had work-related coverage are still unfairly required to pay penalties. **The National Committee recommends that exclusion from penalties should be extended retroactively to all individuals who remained in the work force and had work-related health insurance protection prior to 1983.**

Medicare Coverage for 65-Year-Old Spouses of Younger Workers.

Under current law, an older individual depending on a younger spouse for Medicare coverage is not eligible until the younger spouse turns 62 or becomes eligible for Social Security benefits based on disability. This inequity should be corrected. **The National Committee proposes that the older spouse become eligible for Medicare at 65 after a minimum of twelve months of marriage to a fully insured younger spouse, or automatically at age 65 if the older spouse would have been insured under a previous marriage.**

For example, Mr. Jones (not his real name) is 55--ten years younger than his 65-year-old wife. Mrs. Jones is not eligible for Social Security and Medicare on her own work record, and so will not be able to get Medicare until her husband turns 62 or becomes disabled unless she purchases Part A at high monthly premiums. That means she will be 72 before she is eligible for Part A on her husband's work record. Mrs. Jones was widowed from her first husband when she was in her 50's and married Mr. Jones before she was 60. Her remarriage before age 60 made her ineligible for benefits on the basis of her first husband's earnings.

The irony is that if Mr. and Mrs. Jones were to divorce, her status would revert to that of a widow and she immediately would be eligible for both Social Security widow benefits and for Medicare. And, since she is now over the age of 60, she could remarry Mr. Jones without losing her benefits. There is something wrong with a policy which encourages divorce.

There is no available data showing how many individuals would be affected by this proposed change. However, the cost to Medicare should not be excessive because, if the working spouse has employer insurance, it is primary payer and therefore pays benefits before Medicare.

Mr. Chairman, members of the Committee, we urge you to consider these changes in the Medicare law to help remove barriers to important Medicare coverage. The National Committee stands ready to work with you on these proposals.

WRITTEN STATEMENT
BY
JEFFREY KRAMER
LEGISLATIVE REPRESENTATIVE
FOR THE NATIONAL GRANGE
BEFORE THE
HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
June 12, 1990

My name is Jeffrey Kramer, and I am a Legislative Representative for the National Grange. Our offices are located at 1616 "H" St., N.W. in Washington, D. C. The National Grange represents approximately 325,000 farmers and other residents of rural America in 4,000 local Grange chapters in 40 states. I am presenting the National Grange's views regarding health insurance options, including universal health insurance coverage and expanding the Medicare/Medicaid Program. I would appreciate this statement being included as part of the June 12, 1990 hearing record.

The Grange is a general farm organization whose expressed purpose is to serve the interests of the rural community and the nation. The Grange's policies and programs pertain to a broad array of circumstances that affect the lives of rural Americans and result from our members' action that is generated by total community and national interests. The Grange's policy positions are developed at the local level, are approved at the State level, and are addressed each year at the National Grange's annual meeting of delegates. The Grange's policy reflects a national commitment to share local concerns. At its 123rd Annual Convention, which was held in Greensboro, North Carolina last November, the National Grange's delegate body adopted several resolutions regarding health policy, including universal health insurance coverage and expanding the Medicare/Medicaid Program. Included among these are:

RURAL HEALTH CARE

"The National Grange encourages Congress to reduce the disparity in Medicare reimbursements between rural and urban hospitals.

"The National Grange recommends that the residents of rural communities that are too small to support a full service hospital direct their efforts toward building primary and emergency health care facilities."

MEDICARE/MEDICAID

"The National Grange urges Congress to pass an act allowing Medicare information to be given to an assigned representative. That representative should be allowed to act on behalf of said patient without consignment of Medicare and/or Social Security benefits.

"The National Grange supports legislation to control increases in physicians' costs to those elderly people who are covered by Medicare or Medicaid. We support legislation which would prohibit hospitals and/or doctors from setting fees which discriminate on the basis of the method of payment, such as private insurance, Medicare, Medicaid, cash and other forms of insurance.

"The National Grange urges Medicare to impose hospital outpatient coverage regulations to cover office laser surgery.

"The National Grange supports legislation which requires equity of payment between inpatient and outpatient procedures according to the Medicare DRGs (Diagnostic Related Group).

"The National Grange believes that the rate of increase or decrease of Medicare deductions should be tied to and at the same rate as the inflation or deflation of the general economy.

"The National Grange recommends that Medicare be extended to cover sufficient time for full recovery.

"The Grange supports alternative care for the elderly that would allow them to remain in their homes if at all possible, and seeks legislation that will allow more home care costs to be covered by Medicare benefits.

"The National Grange urges Congress and/or the Executive Branch to investigate the rapid increases in Medicare/ Medicaid costs and report to the public their findings and solutions to slow down medical cost increases without reducing the quality of health care."

UNIVERSAL AND GENERAL HEALTH CARE

"The Grange opposes any national health insurance plan other than catastrophic coverage.

"In the case of catastrophic illness costs, the National Grange believes that a couple should be allowed a "Division of Assets" procedure that would preserve the financial stability of the well member of the couple.

"The National Grange supports legislation that will provide uniform care and services to nursing home patients while protecting their rights.

"The National Grange favors legislation to protect the rights of all people by passing a law stating that "no one will be denied medical attention because of their parents' age, marital status, financial background, religion, race, color or creed.

"We urge the federal government to maintain block grant/ matching funds to states for community health clinics.

"The National Grange opposes legislation that mandates that all employers must provide health care insurance for their employees."

On behalf of the National Grange and myself, I want to thank you for giving us the chance to express our views on the subject of this hearing. The National Grange would also appreciate learning the views of any of the members of the Subcommittee on Health on any of the issues that are covered in this statement.

STATEMENT OF JOHN J. SWEENEY, INTERNATIONAL PRESIDENT
SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

I am John J. Sweeney, President of the Service Employees International Union, AFL-CIO. On behalf of SEIU and its 925,000 members, I would like to thank Chairman Stark and the other members of the Subcommittee on Health, Committee on Ways and Means, for this opportunity to express our views on health insurance options. National healthcare reform is the number one policy priority of SEIU.

SEIU's membership cuts across a wide spectrum of service occupations in both the public and private sectors. Every day, our locals struggle to maintain affordable health benefits in collective bargaining with large and small employers--from big state governments to small school districts, hospitals and nursing homes. This is a battle for access to healthcare, a battle to prevent the loss of coverage and the imposition of cost sharing so high that families cannot afford to use their benefits.

Our locals see the best and the worst of employment-based health insurance. Many of our members still have fully-employer-paid, first dollar coverage. Others have benefit plans that more closely resemble those in the nonunion sector. We represent workers in low-wage occupations such as nursing home workers and commercial-sector janitors who would be working without health insurance if not for their union membership. And SEIU is actively organizing *in* industries where the absence of health benefits is the norm.

Like many other unions, SEIU has had long experience with health plan cost containment beginning even before the first round of double-digit health cost increases in the early eighties. It's not hard to see why--cost controls are an alternative to benefit reductions or increased worker cost sharing and also help reduce the financial burden of health benefits to employers. From pre-admission screening to wellness programs--we have tried them all and continue to recommend their implementation by local unions whenever possible.

SEIU's experience has revealed, however, that plan-by-plan cost containment measures--whether HMOs, managed care, PPOs and so on--simply cannot get a handle on provider reimbursement. This uncoordinated approach doesn't give providers enough incentive to control costs. Instead, they just shift the cost from the stronger payers to the weaker ones. Plan-by-plan cost containment becomes a game of beggar-thy-neighbor--one plan's discount is another plan's rate increase.

As we watch the annual rate of increase in the cost of health coverage shoot past 20 percent, employers and unions feel a deep sense of frustration. We've done what we're supposed to do, we've taken our medicine, but we're not getting better. In fact, the problem is getting worse.

SEIU has redoubled its efforts to promote national health-care reform. SEIU participates actively in the Dunlop Group of Six and the National Leadership Coalition for Health Care Reform. International President John Sweeney was appointed to the Advisory Council on Social Security, also known as the Steelman Commission, which is charged with taking a comprehensive look at health care. Along with the AFL-CIO, SEIU has launched a national grassroots campaign aimed at educating and mobilizing our membership around the need for national healthcare reform.

The primary purpose of our Grassroots Healthcare Reform Campaign is to focus the energy for health reform at the federal level--the only level where comprehensive reform can be enacted. But we also want to support state initiatives which provide interim relief and which are themselves building blocks for national reform.

State reform initiatives play an important role in the overall health reform effort. We encourage them and support them. At the same time, we must challenge the Reagan era belief that the federal government is not responsible for ensuring health coverage and that states should accept the responsibility instead.

Universal health coverage to quality care, with real cost containment, can only be won at the national level and, consequently, our energies should be focused there.

SEIU stands ready to explore a variety of alternatives to address the triple problems of rapidly rising costs, declining access and uncertain quality. We seek an approach which serves the interests of both union members and unorganized workers as well as all non-working Americans. Accordingly, any proposal must be based on these ten principles: universality; public accountability; affordability and accessibility; comprehensiveness; equitable and progressive financing; fairness; portability; cost containment; quality assurance; and public/private administration.

Our reform strategy is grounded in the firm belief that only a federal approach can achieve the three objectives of universal access, uniform quality standards, and cost containment. States and/or regional structures would have an important role within a national, coordinated system of financing and delivering health care. Until national healthcare reform is achieved, SEIU will continue to work for passage of state, as well as federal measures which provide interim relief. However, we will not support efforts which detract from our primary objective either because they divert resources from that objective or because they are inconsistent with national reform.

The Subcommittee's hearings on health insurance options are timely and will help build the momentum for systemic healthcare reform. SEIU urges Congress to maintain progress towards achieving healthcare reform on the national level.

Thank you, Mr. Chairman.

32-826 (160)